PRINTED: 12/04/2018 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		10/25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
E 000	Initial Comments		E 000			
F 000	survey was conducted 10/25/18. The facility CFR Part 483.73, Recars Facilities. INITIAL COMMENTS	was in compliance with 42 quirement for Long-Term	F 000			
	survey was conducted 10/25/18. Corrections compliance with the formal compl	s are required for ollowing 42 CFR Part 483 are requirements. The Life				
F 558 SS=E	163 at the time of the consisted of 42 curre (Residents #265, #55 #8, #119, #113, #58, #117, #31, #95, #114 #2, #133, #66, #77, #110, #23, #68, #51, and four closed recor #166, #115 and #167 Reasonable Accomm	5, #46, #101, #316, #54, #10, #73, #266, #128, #112, , #60, #52, #74, #106, #108, 1161, #158, #318, #5, #149, #48, #25, #64, #83 and #42) d reviews (Residents #317,	F 558	3	12/1/18	
	services in the facility accommodation of repreferences except we endanger the health cother residents. This REQUIREMENT by: Based on observation	sident needs and		1.Corrective Action		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 11/16/2018

Facility ID: VA0270

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		10	10/25/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		1/23/2010	
				7300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 558	Continued From page	e 1	F 55	58			
	was determined the f	acility staff failed to ensure a each for three of 46		The call bells for residents # and #54 were observed on			
		#161, #54, #158 and failed to pices was honored for one of		located within reach of the r	esident.		
		urvey sample, Resident #46.		The volume for the televisio #42 was repaired on 10/24/			
	,	ailed to ensure the call bell ent's reach for Resident #161.		working order. Both residen 46 are watching and listenin televisions.			
	#54's call bell (a devi	ailed to ensure Resident ce with a button that can be		2.Other Potential Residents			
	pushed to alert staff when assistance is needed), was within the resident's reach.			All residents who rely on the bells for assistance have the			
		ailed to ensure Resident vithin the resident's reach.		be affected. A 100% audit of was completed on 10/24/18	to validate		
	4. The facility staff fa Resident #46 to choo preferred television p			that the residents call bell w reach. Any areas of non-cor immediately corrected and s responsible were counseled	mpliance was		
	The findings include:			All residents who have telev rooms have the potential to 100% audit of all televisions	be affected. A		
	2/26/16 with diagnos limited to: depression	as admitted to the facility on es that included but were not n, high blood pressure,		completed to validate that the was working properly. All tel noted to be in working order	levisions were		
		hronic obstructive pulmonary anxiety disorder, and		Systemic Changes Nursing staff have been re-	oducated on		
	assessment, a quarte assessment reference	S (minimum data set) erly assessment, with an e date of 10/11/18, coded ng a three of 15 on the BIMS		Nursing staff have been re- the importance of making su residents call bell is within re leaving the residents room.	ure that the		
	(brief interview for me the resident was not cognitive decisions.	ental status) score, indicating capable of making daily The resident was coded as understand and to make		Facility staff have been re-e the process for reporting to when a residents television properly	maintenance		

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	DER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226)E		
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the coordinate of the coordina	ded as requiring exessing and personal decare plan dated 3 cumented, "Providenbulate as needed." 10/23/18 at approservation was madher bed; the call bed to away from the result of a to a way from the floor. 10/25/18 at approserview was conducted if Resident #16 ll, CNA #2 replied "With ked if Resident #16 ll, CNA #2 replied "In 10/25/18 at approserview was conducted in the attention of stolied, "Ring the call ll bell should be plad or within their read." When informed	and. The resident was also stensive assistance for all hygiene. 3/2/16, for Resident #161 assistance to transfer and " ximately 1:09 p.m., an a se of Resident #161 sleeping all was approximately one sident laying on the floor. ximately 3:44 p.m., a made of Resident #161 he call bell was bet away from the resident away from the resident away from the resident asked where bell should be positioned, in reach at all times." When asked where all awas able to press the call ayes." ximately 10:20 a.m., an atted with LPN (licensed When asked how residents' aff if they need help, LPN #7 bell." When asked where a faced, LPN #7 replied "On the arch if they are not in the that Resident #161 call bell hin reach, LPN #1 stated "It	F 55	Unit Managers will complete bell audit 3 times a week for validate that the residents ca within reach. Any areas of non-compliance will be imme corrected and staff responsible counseled. Facility Maintenance staff will weekly audits x 3 months, of to validate that all televisions working order. If any television need of repair the repair will of as soon as possible. 4.Monitoring The results of all audits will be to the QAPI Committee for recommendations. 5.Date of compliance 12/1/18	3 months to all bell is ediately ble will be ll conduct all television are in be taken ca	ons	

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F 558	Administrator and A Nursing were made The facility policy er Light" documented, bed or confined to a within easy reach of No further information 1. Not enough thyro body's needs. This from the website: https://www.nlm.nih.sm.html. 2. Disease that make can lead to shortness types are chronic brown the main cause of the to substances that in this is usually cigar chemical fumes, or information was obtain the substances that in this is usually cigar chemical fumes, or information was obtain the substances that in this is usually cigar chemical fumes, or information was obtain the substances that in this is usually cigar chemical fumes, or information was obtain the substances that in this is usually cigar chemical fumes, or information was obtain the facility staff if was within the residence of the facility staff in the fa	member) #2, Assistant SM #5, the Director of aware of the findings. Ititled "Answering the Call "5. When the resident is in chair be sure the call light is the resident." On was provided prior to exit. Id hormone to meet your information was obtained gov/medlineplus/hypothyroidi es it difficult to breath that is of breath). The two main conchitis and emphysema. COPD is long-term exposure ritate and damage the lungs. ette smoke. Air pollution, dust can also cause it. This ained from the website: gov/medlineplus/copd.html. failed to ensure Resident vice with a button that can be when assistance is needed),	F 55	58			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 558	- 15, 15 - being cog decisions. Resident extensive assistant locomotion, dressint totally dependent with member for person. On 10/23/18 at 11:5 Resident # 54 revealed it was lying of the resident's being the resident's being the resident's being the resident was lying of the resident's being on the floor or bed. On 10/24/18 at 2:50 conducted with LPN in presence of Resident was lying on the floor or bed. On 10/24/18 at 2:50 conducted with LPN in presence of Resident's surveyor asking 10/23/18 during the stated "Yes." Resident's surveyor asking 10/23/18 during the stated "Yes." Resident's bed. When a placement of the call bell was lying # 54's bed. When a placement of the call placement of the cal	status (BIMS) of a score of 0 nitively intact for making daily t # 54 was coded as requiring the of one staff member for g and toilet use and being ith the assistance of one staff tal hygiene and bathing. 66 a.m., an observation of taled he was lying in his bed. with Resident # 54, he was so call bell Resident # 54 was Observation of the call bell g on the floor on the right side d. 65 p.m., an observation of taled he was in bed watching t # 54 was asked to activate the tale the tale to locate the call bell revealed it was the right side of the resident's 10 p.m., an interview was 11 (licensed practical nurse) # 8 dent # 54 was asked if recalled to about his call bell on interview, Resident # 54 lent # 54 further stated, "I N # 8 was then informed that the g on the floor under Resident	F	558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 558	(administrative sta administrator and administrator, ASM # 5 director of medical director with findings. No further information References: (1) A swallowing dobtained from the https://www.nlm.nisorders.html. (2) Also called: He Quadriplegia. Parfunction in part of something goes with pass between your can be complete to both sides of your one area, or it can information was of https://medlineplus. (3) A stroke. Whe brain stops. A stroattack." If blood fifew seconds, the boxygen. Brain cells damage. This info website: https://medlineplus.	proximately 5:40 p.m., ASM Iff member) # 2, the ASM # 2, assistant If # 4 assistant administrator, If nursing and ASM # 6, If ere made aware of the Ition was provided prior to exit. Itiosorder. This information was	F	558			

- ,	IMBED:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495227	B. WIN	G		10/	25/2018
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CH DEFICIENCY MUST BE PRECEDED BY	Y FULL PRE	FIX	,		(X5) COMPLETION DATE
from the website: w.nlm.nih.gov/medlineplus/highml. cility staff failed to ensure Resid ll bell was within the resident's r # 158 was admitted to the facilit with diagnoses that included but d to: heart failure (1), depressive 2), anemia (3) and chronic obstry disease (4). # 158's most recent MDS (minin a quarterly assessment with an ent reference date) of 10/11/18, # 158 as scoring a 13 on the bri for mental status (BIMS) of a sc being cognitively intact for makin Resident # 158 was coded as extensive assistance of one staff or all activities of daily living. 18 at 9:37 a.m., an observation # 158 revealed she was sitting ung an interview, Resident # 158 ocate and activate the call bell. # 158 was unable to locate it. on of the call bell revealed it wa nt's pillow at the level of her neo d with LPN (licensed practical not asked how often the placement mould be checked LPN # 8 state ecked during rounds and prn (as When informed of the observa	dent deach. Ey on the were described and the second of the second of the second of the described and the second of the second	F 558			
of L = AG = CfVr and SYC()? Something / Sychological Sych	SUPPLIER SUMMARY STATEMENT OF DEFICIENCY CH DEFICIENCY MUST BE PRECEDED B GULATORY OR LSC IDENTIFYING INFORM d From page 6 from the website: ww.nlm.nih.gov/medlineplus/high.ml. acility staff failed to ensure Residal bell was within the resident's resident with diagnoses that included but d to: heart failure (1), depressive (2), anemia (3) and chronic obstry disease (4). # 158's most recent MDS (mining a quarterly assessment with an inent reference date) of 10/11/18, # 158 as scoring a 13 on the brid for mental status (BIMS) of a scoring cognitively intact for making. Resident # 158 was coded as extensive assistance of one state for all activities of daily living. /18 at 9:37 a.m., an observation # 158 revealed she was sitting to make a	SUPPLIER LITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (CH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) d From page 6 from the website: www.nlm.nih.gov/medlineplus/highbloodpr ml. dill bell was within the resident all bell was within the resident's reach. # 158 was admitted to the facility on with diagnoses that included but were doto: heart failure (1), depressive (2), anemia (3) and chronic obstructive by disease (4). # 158's most recent MDS (minimum and a quarterly assessment with an ARD benent reference date) of 10/11/18, coded # 158 as scoring a 13 on the brief for mental status (BIMS) of a score of 0 being cognitively intact for making daily and chronic making daily and chronic making daily and cate and activate the call bell.	SUPPLIER LITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES CHO DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) d From page 6 from the website: ww.nlm.nih.gov/medlineplus/highbloodpr ml. dill bell was within the resident's reach. # 158 was admitted to the facility on with diagnoses that included but were d to: heart failure (1), depressive (2), anemia (3) and chronic obstructive ry disease (4). # 158's most recent MDS (minimum a quarterly assessment with an ARD ment reference date) of 10/11/18, coded # 158 as scoring a 13 on the brief for mental status (BIMS) of a score of 0 being cognitively intact for making daily in mental status (BIMS) of a score of 0 being cognitively intact for making daily. Resident # 158 was coded as extensive assistance of one staff for all activities of daily living. /18 at 9:37 a.m., an observation of # 158 revealed she was sitting up in mg an interview, Resident # 158 was locate and activate the call bell. # 158 was unable to locate it. ion of the call bell revealed it was under ent's pillow at the level of her neck. /18 at 2:50 p.m., an interview was d with LPN (licensed practical nurse) # asked how often the placement of the hould be checked LPN # 8 stated, "It necked during rounds and prn (as "When informed of the observation of # 158 not being able to locate and	SUPPLIER LITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES SULMARY STATEMENT OF DEFICIENCIES SULATORY OR LSC IDENTIFYING INFORMATION) TAG From page 6 from the website: ww.nlm.nih.gov/medlineplus/highbloodpr ml. scility staff failed to ensure Resident all bell was within the resident's reach. # 158 was admitted to the facility on with diagnoses that included but were d to: heart failure (1), depressive 2), anemia (3) and chronic obstructive y disease (4). # 158's most recent MDS (minimum a quarterly assessment with an ARD being cognitively intact for making daily a Resident # 158 was coded as extensive assistance of one staff for all activities of daily living. //18 at 9:37 a.m., an observation of # 158 revealed she was sitting up in ng an interview, Resident # 158 was locate and activate the call bell. # 158 was unable to locate it, ion of the call bell revealed it was under entsy pillow at the level of her neck. //18 at 2:50 p.m., an interview was d with LPN (licensed practical nurse) # asked how often the placement of the hould be checked LPN # 8 stated, "It hecked during rounds and prn (as "When informed of the observation of # 158 not being able to locate and "When informed of the observation of # 158 not being able to locate and "When informed of the observation of # 158 not being able to locate and "When informed of the observation of # 158 not being able to locate and	SUPPLIER LITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES GOT DEFICIENCY MUST BE PRECEDED BY PULL JULATORY OR LSC IDENTIFYING INFORMATION) d From page 6 from the website: www.nlm.nih.gov/medlineplus/highbloodpr ml. citility staff failed to ensure Resident all bell was within the resident's reach. #158 was admitted to the facility on with diagnoses that included but were d to heart failure (1), depressive (2), anemia (3) and chronic obstructive y disease (4). #158' most recent MDS (minimum a quarterly assessment with an ARD hent reference date) of 10/11/18, coded #158 as scoring a 13 on the brief for mental status (BIMS) of a score of 0 being cognitively intact for making daily a. Resident #158 was coded as extensive assistance of one staff for all activities of daily living. #168 at 9.37 a.m., an observation of #158 revealed she was sitting up in ng an interview, Resident #158 was locate and activate the call bell. #158 was unable to locate it. ion of the call bell revealed it was under ent's pillow at the level of her neck. #188 at 2:50 p.m., an interview was d with LPN (licensed practical nurse) # asked how often the placement of the hould be checked LPN # 8 stated, "It hecked during rounds and prn (as "When informed of the observation of #158 not locate and

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F 558	On 10/25/18 at appri (administrative staff administrator and A administrator, ASM ASM # 5 director of medical director we findings. No further information in what to pump oxygen-ricle efficiently. This cause throughout the body obtained from the whost of us feel this short periods. Clinical disorder in which feor frustration interfeor more. This information website: https://medlineplus.	she could access it. roximately 12:45 p.m., ASM member) # 2, the SM # 2, assistant # 4 assistant administrator, nursing and ASM # 6, re made aware of the on was provided prior to exit. nich the heart is no longer able h blood to the rest of the body ses symptoms to occur //. This information was	F 5			
	can lead to shortnes was obtained from t	kes it difficult to breath that ss of breath. This information the website: .gov/medlineplus/copd.html.				

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F 558	Continued From pag	ge 8	F 55	58			
	Resident # 46 to che preferred television Resident # 46 was a 10/31/16 with diagram not limited to: deme anemia (3) and spin Resident # 46's mosset), an annual asset (assessment references from the second of th	admitted to the facility on oses that included but were ntia (1), dysphagia (2), all stenosis (4). St recent MDS (minimum data essment with an ARD nce date) of 08/30/18, coded oring a 5 (five) on the brief status (BIMS) of a score of 0 severely impaired of g daily decisions. Resident # quiring extensive assistance for locomotion, dressing, nobility and being totally raff member for transfers, giene and bathing. Section F stomary Routine and esident # 42 as 1 (one) - "Very how important is it to you to s?" I p.m., observation of aled she was lying in bed hing the television on her side vation of her wall-mounted					
	television program. television revealed to coming from the tele room revealed Resi was lying in bed with phones on her head	t was on and tuned into a Further observation of the that there was no sound evision. Observation of the dent # 46's roommate, she h her eyes closed and head I and over her ears. When ht # 46's roommate was					

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F 558	stated, "The T.V." Of for Resident # 46's romounted on the wall revealed that there we television was off. We Resident # 46's room # 4 pointed to Reside was mounted on the room. CNA # 4 stated her roommate's (resident # 46's televelooks at her own teled CNA # 4 verbally cond When asked if she the was okay, CNA # 4 do On 10/25/18 at 8:55 Resident # 46 reveal awake looking/watch of the room. Observatelevision revealed it television revealed the coming from the televeroom revealed Resident was sittle closed and the heady her ears and being a with breakfast. When 46's roommate was lightly the T.V." Observate Resident # 46's room on the wall at the foothere was no picture When asked what televeroom revealed what televeroom revealed was lightly the T.V." Observate Resident # 46's room on the wall at the foothere was no picture when asked what televeroom revealed what televeroom revealed was lightly the T.V."	rtified nursing assistant) # 4 bservation of the television commate, which was at the foot of the bed, ras no picture and the //hen asked what television mate was listening to, CNA ent # 46's television, which wall on the A-side of the d, "She's listening to that d, "(Resident # 42) listens to dent # 46) T.V." When 6's roommate listens to ision while Resident # 46 vision without any sound, firmed the arrangement iought that this arrangement idn't have a response. a.m., observation of ed she was lying in bed ing the television on her side ation of her wall-mounted was on and tuned into a Further observation of the further was no sound vision. Observation of the	F	558			

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F 558	the wall on the A-sic "She's listening to the "(Resident # 42) list (Resident # 46) T.V 46's roommate liste television while Resident # 46's roommate liste television without an confirmed the arrand thought that this arrandidn't have a responsion on 10/25/18 at 9:14 Resident # 46 revealed it was on a coming from it. What television Resident asked if she wanted Resident # 46 state. The "Activity Evaluation 10/17/2016 document Viewing/Radio" Currous: Enjoys active pets/animals, group appropriate weather games and socials. documented, "Will pleisure activities of civisitors."	evision, which was mounted on the of the room and stated, and one." CNA # 3 stated, tens to her roommate's ." When asked if Resident # ns to Resident # 46's sident # 46 looks at her own my sound CNA # 3 verbally gement. When asked if she angement was okay, CNA # 3 nse. If a.m., an observation of alled she was in bed looking at tervation of the television and there was no sound en asked if she could hear the # 46 stated, "No." When It to hear her television d, "Yes but not loud." Ation" for Resident # 46 dated ented, "C. 11. TV Program rent interest." The care plan with a revision date esident # 46 documented, wities such as music, activities, outdoors in r, religious/spiritual, exercise,	F 5	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON IDENTIFICATION NUMBER: A. BUILDING		TIPLE CONSTRUCTION NG	. ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		1	0/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIF 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 558	to select preferred to a greed Resident and were not honored. Not aware of this under the conducted with ASM. When informed of the selection o	roximately 12:45 p.m., ASM femember) # 2, the SM # 2, assistant administrator. To choose activities and roximately 12:45 p.m., ASM femember) # 2, the SM # 3, assistant administrator, and assistant administrator. To choose activities and roximately 12:45 p.m., ASM femember) # 2, the SM # 3, assistant administrator, and assistant administrator. To choose activities and roximately 12:45 p.m., ASM femember) # 2, the SM # 3, assistant administrator, and and assistant administrator, and assistant administrator. In the information was website: gov/ency/article/000739.htm.	F	558			
		/ebsite: i.gov/medlineplus/swallowingdi					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION (3 BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/	25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 100 FOREST AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 558 F 577 SS=C	the website: https://www.nlm.nih.g (4) A narrowing of the pressure on the spina openings (called neuropenings (called neuropenings)	pormation was obtained from gov/medlineplus/anemia.html e spinal column that causes al cord, or narrowing of the ral foramina) where spinal al column. This information e website: by/ency/article/000441.htm.		5577			12/1/18	
	(i) Examine the result of the facility conduct surveyors and any planespect to the facility; (ii) Receive information client advocates, and to contact these ager §483.10(g)(11) The facility post in a place real and family members residents, the results the facility. (ii) Have reports with certifications, and conrespecting the facility years, and any planed respect to the facility, to review upon reque	es of the most recent survey ed by Federal or State an of correction in effect with and on from agencies acting as be afforded the opportunity ncies. acility must idily accessible to residents, and legal representatives of of the most recent survey of respect to any surveys, mplaint investigations made during the 3 preceding of correction in effect with available for any individual st; and availability of such reports in						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495227	B. WING		10/	10/25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 577	information about cor This REQUIREMENT by: Based on observation and staff interview, it facility staff failed to prior Survey results where the previous 3 years available for review. The Findings include During the course of survey, a meeting was Resident Group on 1 current cognitively into During the course of asked if they were aw previous years' survey responded that they where the facility's posting of small binder was four from a hook on the wheelchair height. The contain the most receit those were survey results	lic. not make available identifying implainants or residents. is not met as evidenced in, resident group interview, was determined that the properly display notice that were available for review. displayed alerting residents, entatives and visitors that of survey results were d: the annual certification is conducted with the 0/23/18 at 2:00 p.m. eight react residents attended. The Group meeting, when were of how to review by results. The Group all did not. p.m., this surveyor inspected of prior survey results. A and in the main lobby hanging all, within easy reach of the binder was found to the survey results report. There was no notice in the earby that the previous 3 ts and the plans of	F 57'	1. Corrective Action The notice has been re-posted at the receptionist desk and in the survey be that identifies the location of the survey for the past 3 years. 2. Other Potential Residents All residents have the potential to be affected. A notice has been posted at receptionist desk and in the survey be that identifies the location of the survey for the past 3 years. A meeting was he with the resident council on 11/8/18 at the residents in the group were show location of the survey results for the previous 3 years. 3. Systemic Changes An audit will be completed weekly x3 months to validate that the notice of location of survey results is present. 4. Monitoring The results of all audits will be forward to the QAPI Committee for review an recommendations.	the ook eys held and n the		
	This surveyor took th	e Survey Results binder to		5.Date of compliance			

STATEMENT OF DEFICIEN AND PLAN OF CORRECTI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		10/25/2018	
NAME OF PROVIDER OF WESTPORT REHAB		D NURSING CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
	ACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	TION
the office #1, the 3 the 3-ye ASM #1 Adminis survey reception know to survey recan add binder do The Adminformed on 10/25 provided F 584 Safe/Cle SS=D CFR(s): §483.10 The resist comfortate but not 1 supports The faci §483.10 homelik use his apossible (i) This is receive physical indepen (ii) The faci indepen (iii) The faci independent in	Senior Admin ar look back contacted Astrator, who stesults were kn desk. When ask the receesults binder a notice to the isplayed on the finding of the finding and for the for daily living the first for the finding and for the finding and for the finding and for the finding and sensitive and sensitive and sensitive and sensitive and deactility shall experiences.	rative Staff Member (ASM) istrator, and asked where of survey results were kept. SM #4, the Assistant tated that the 3 years of kept in a binder at the n asked how a person would ption desk for the 3-year n, ASM #4 stated "well, we nat book" (the survey results the wall). d Director of Nursing were tigs at the end of day meeting there documentation was table/Homelike Environment therefore to a safe, clean, the to	F 584	12/1/18	12/1/18	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		0/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	Continued From pag	e 15	F 5	84		
		seeping and maintenance o maintain a sanitary, orderly, rior;				
	§483.10(i)(3) Clean In good condition;	ped and bath linens that are				
		closet space in each ecified in §483.90 (e)(2)(iv);				
	§483.10(i)(5) Adequate levels in all areas;	ate and comfortable lighting				
	levels. Facilities initia	table and safe temperature ally certified after October 1, a temperature range of 71 to				
	sound levels.	maintenance of comfortable Γ is not met as evidenced				
	Based on observation	on, staff interview, facility d clinical record review, it		Corrective Action		
	was determined that the facility staff failed to maintain a homelike environment in one of two dining areas and maintain a resident's room in a homelike environment for one of 46 residents in the survey sample, Resident #42.			The staff serving the meals we re-educated on 10/24/18 how meals to promote a homelike at the television for resident # 42 repaired on 10/24/18.	to serve atmosphere	
		ailed to serve resident's meal r in the first floor dining area.		2.Other Potential Residents		
	42's television in wor			Residents that are served mea first floor dining have the poter affected. Nursing staff have be	ntial to be een	
	The findings include:			re-educated on how to serve n promote a homelike atmosphe		
	 I he facility staff fa 	ailed to serve resident's meal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _	B. WING		10/25/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
				7300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 584	Continued From page	e 16	F 5	84			
F 584	in a homelike manner A dining observation at 12:30 p.m., in the room). An observation sixteen residents sea fifteen residents in the were observed serving Observation of the semembers taking the dishes, utensils and and placing the items Observations of the othey were left on the in front of the resident observation of the directived their meal of member was observed their meal of member was observed the resident's cups, of dinner plate in front of assisting the resident. On 10/24/18 at 3:50 conducted with CNA 5. When asked what residents, CNA # 5 s When asked how the served their lunch on "In the first floor dining take everything off the on the warmer plates the plates are placed if she thought it was	was conducted on 10/23/18 first floor dining area (activity on of the room revealed ated at tables for lunch. For e dining area, staff members are residents' their meal. erving revealed staff resident's cups, dessert dinner plates from the trays in front of each resident. dinner plates revealed that warming bases when placed at while they ate. Further ning revealed one resident on the serving tray. The staff ed placing the tray containing dessert dishes, utensils and of the resident and then the with eating their meal. p.m., an interview was (certified nursing assistant) # the facility means to the tated, "It's their home." resident's should have been 10/23/18, CNA # 5 stated, ag area I was suppose to the tray. Their plates were left in the main dining room on the table." When asked thomelike to leave the plates warmer plates, CNA # 5	F 5	All residents who have tel rooms have the potential Facility staff have been re the process for reporting the process for reporting the when a residents television properly A 100% audit of all televis completed on 10/24/18 to television was working protelevisions were noted to order. 3. Systemic Changes A audit will be completed months to validate that reserved meals in the first flowing served meals in a henvironment. Any areas on non-compliance will be imcorrected and staff resport counseled. Facility Maintenance staff weekly audits x 3 months to validate that all television working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order. If any televineed of repair the repair working order.	to be affected. e-educated on to maintenance on is not working sions was validate that the operly. All be in working weekly x 3 sidents that are oor dining are omelike of imediately nsible will be will conduct of all televisions ons are in visions are in vill be taken care		
		? a.m., an interview was (other staff member) # 5, nen asked about the		5.Date of compliance			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	plates and the servia homelike atmospher plate on the base of the observation of lefloor dining area, Othomelike." The facility's policy documented, "Policy audits the food and to ensure that reside dining is a safe and residents." Under "Implementation" it of food and beverages trays and placed on setting (Notes: Whee resident, the except resident's care plane. On 10/24/18 at app (administrator and A administrator, ASM ASM # 5 director of medical director we findings. No further information.	ing served on the warming ing tray, OSM # 5 stated, "For here you wouldn't keep the in the tray." When informed of unch being served on the first SM # 5 stated, "It's not." "Dining Room Audits" y Statement: Our facility nutrition services department ents needs are met and that pleasant experience for Policy Interpretation and locumented, "g. Whether all is are removed from resident's in the table in a homelike ent this is not feasible for a cions must be noted in the on." Toximately 5:40 p.m., ASM in member) # 2, the SM # 2, assistant # 4 assistant administrator, nursing and ASM # 6, re made aware of the on was provided prior to exit. Ifailed to maintain Resident #	F 5	, , , , , , , , , , , , , , , , , , ,		
	11/03/15 with diagn not limited to: vision	admitted to the facility on oses that included but were loss, both eyes, hearing loss, sphagia (2), hemiplegia (3)				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER	·	730	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226		
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F 584	Resident # 42's mos set), a quarterly asse (assessment referer Resident # 42 as so interview for mental - 15, 5 (five) - being cognition for making 42 was coded as recof one staff member use and bed mobility of one staff member hygiene and bathing Customary Routine Resident # 42 as 1 ("D. how important is news?" On 10/24/18 at 5:50 Resident # 42 reveal headphones on. CN # 4 entered the room provide personal cal p.m., an interview when she finished p Resident # 42 was be When asked about F CNA stated, "She us	·		5584		AIE	DAIL
	Observation of Residuals mounted on the revealed that there will when asked what tellistening to CNA # 4 Resident # 42's room on the wall on the Astated, "She's listenials was mounted by the stated of the stated	dent # 4 stated, "The T.V." dent # 42's television, which wall at the foot of the bed, was no picture and was off. elevision Resident # 42 was pointed to the television for mate, which was mounted eside of the room. CNA #4 ng to that one." Observation elevision revealed it was on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED			
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 584		e however there was no	F 5	584		
	listens to her roomma Resident # 42 was lis	# 4 stated, "(Resident # 42) ate's T.V." When asked why stening to her roommate's tated she didn't know.				
	observed being assis breakfast. Observati was sitting up in bed listening to her roomr	a.m., Resident # 42 was sted by a staff member with on revealed Resident # 42 with headphones on mate's television. Further Resident # 42's television				
		on" for Resident # 42 dated ted, "C. 11. TV Program ent interest."				
	of 11/21/2018 for Res "Focus: Prefers not to to being blind, does r of people and prefers "Interventions" it docu (one-to-one) activity discussions of weath	care plan with a target date sident # 42 documented, o attend group activities due not like to be around groups to stay in room." Under umented, "Provide 1:1 visits of potential interest (i.e. er, every day activities/rec mily) 2 (two) times per week /."				
	conducted with LPN (9, unit manager. After the observations of R	a.m., an interview was (licensed practical nurse) # er LPN #9 was informed of tesident # 42 listening to her n, LPN # 9 stated, "I was not sterday."				
		a.m., an observation staff member) # 10, director DSM # 11, maintenance				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING		,	10/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			
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F 584	When asked what the 42's room, OSM # 1 Resident # 42's telewas informed about stated, "I was verbamy colleague (OSM) We are in the procesasked if there was a OSM # 10 stated ye requested a copy of 10. On 10/25/18 at 9:53 a copy of the facility Request Log" from Completed the work television OSM # 10 staff member] # 4, a The facility's "Daily I documented, "Locat Description: (Residesound is connected Requested Time/ Da Requested by: Nurs On 10/25/18 at 10:0 conducted with ASM When asked if she I for the repair on Res # 4 stated yes. Whether repair needed for 42's room, ASM # 4 administrative nurse about it until this more	of Resident # 42's room. They were doing in Resident # 0 stated they were checking vision. When asked when he the television, OSM # 10 Illy informed this morning by # 11- maintenance worker). The so of fixing it now." When work order for the repair, so this surveyor then the work order from OSM # The a.m., this surveyor received to sure and the work order from OSM # The a.m., this surveyor received to sure and the work order from OSM # The a.m., this surveyor received to sure and the work order from OSM # The a.m., this surveyor received to sure and the work order from OSM # The a.m., this surveyor received to sure and the work order from OSM # The analysis of the surveyor received to the surveyor received	F 58	34			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		10/25/2018		
	ROVIDER OR SUPPLIER	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODI 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION		
F 584	ASM # 5 director of medical director we findings. No further information of the pump oxygen-rice efficiently. This caust throughout the bod obtained from the whottps://medlineplus (2) A swallowing disobtained from the whottps://medlineplus (2) A swallowing disobtained from the whottps://www.nlm.nih.sorders.html. (3) Also called: Her Quadriplegia. Parafunction in part of y something goes wrice pass between your can be complete or both sides of your tone area, or it can information was obhttps://medlineplus (4) A stroke. When brain stops. A strokattack." If blood flooding in part of the parameters of the parameter	ASM # 2, assistant # 4 assistant administrator, finursing and ASM # 6, free made aware of the fon was provided prior to exit. Thich the heart is no longer able the blood to the rest of the body ses symptoms to occur y. This information was website: gov/ency/article/000158.htm. Forder. This information was website: gov/medlineplus/swallowingdi Iniplegia, Palsy, Paraplegia, glysis is the loss of muscle our body. It happens when ong with the way messages brain and muscles. Paralysis partial. It can occur on one or body. It can also occur in just be widespread This tained from the website:	F 584	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	TE SURVEY MPLETED	
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	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	•		
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F 584 F 607 SS=D	Develop/Implemer CFR(s): 483.12(b) §483.12(b) The far implement written §483.12(b)(1) Profineglect, and explois misappropriation of the second of the seco	s.gov/ency/article/000726.htm. at Abuse/Neglect Policies (1)-(3) cility must develop and policies and procedures that: nibit and prevent abuse, itation of residents and af resident property, ablish policies and procedures such allegations, and ude training as required at 5, NT is not met as evidenced at interview, staff interview, eview, and clinical record armined that the facility staff at abuse policies and report an e to the appropriate agencies ents in the survey sample, an allegation of abuse made of this writer and reported to the 0/23/18.	F 5		vas faxed to Certification s egation of or tial to be stant rvices was the nts of	12/1/18	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	most recent MDS (mi assessment was qual ARD (assessment recession of Resident #23 was concognitive function see BIMS (Brief Interview Resident #23 was condependence on one spersonal hygiene, an assistance with two obed mobility, and transcoded in Section B (HVision), as sometime sometimes being und communication. On 10/23/18 at 3:30 proconducted with Resident material with a stick. Resident #23 could not with the with a stick. Resident #23 could not woman was her room "No." When asked we resident #23 stated that the back to be afterward woman was her room "No." When asked we resident #23 stated that the stated she had not resident that it probably "show #23 stated she still feronted to ASM (addressed to 10/23/18 at 3:46 preported to ASM (addressed to 2 a.m. to 10/23/18 at 3:46 preported to ASM (addressed to 2 a.m.).	o diabetes. Resident #23's inimum data set) rterly assessment with an ference date of 8/16/18. ded as severely impaired in oring 05 out of 15 on the for Mental Status) exam. ded as requiring total staff member with dressing, d bathing; and extensive or more staff members with insfers. Resident #23 was dearing, Speech, and is understanding others and derstood by others for so.m., an interview was dent #23. During the 23 alleged that a woman had desident #23 identified the fan who runs this place." To trecall her name. Resident the woman had then gone dis. When asked if this inmate, Resident #23 stated, that kind of stick was used, that is was the end of a fent #23 stated that it finat morning. Resident #23 ported this to anyone and lid be looked at." Resident lit safe at the facility. D.m., this allegation was ministrative staff member) ASM #2 stated that she	F	ex re to fee th 111 re ex th TI fa to ap will 4. Th to re	ny allegations of abuse, neglect, eploitation or mistreatment will be ported to the Administrator and reported to the Administrator and the facility's abuse policy. Effective 1/15/18 the facility Administrator will aport all allegations of abuse, neglect, eploitation or mistreatment and initiate internal investigation. The QAPI Committee will review the cility's Grievance Log weekly x 3 more validate potential abuse reporting, if explicable was completed in accordant the facility's abuse reporting policy. Monitoring The results of all audits will be forward the QAPI Committee for review and commendations. Date of compliance 2/1/18	nd with e e nths ce /.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		495227	B. WING			10/25/2018
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F 607	the assistant admini walking into Resider walking into Resider On 10/23/18 at approadministration preserved and herecall the above allewitness statements. On 10/25/18 at 8:37 (facility reported incompanies of ASM #3. ASM #3 soon a FRI because sheet Resident #23 on 10 no recollection of here was the facility of the walking and again that more stated that Resident #23 and here was the facility due was the	p.m., ASM #2 and ASM #3, strator were observed in the work of the	F	607	YY)	
	abuse, ASM #3 state the process for report that typically the prowithin a 2-hour wind agencies. ASM #3 stwo-hour window, stallegation. ASM #3 report Resident #23 had not hitting her in the heat investigation. ASM #3 was alert and orient one had come into the	e for reporting allegations of ed that she was. When asked orting abuse, ASM #3 stated ocess was to report abuse ow to the appropriate stated that during this ne is also investigating the stated again that she did not sallegation because or recollection of anyone and with a stick during the #3 stated that her roommate ed, and also stated that no he room at 2 a.m. When you up report should be				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	` '	DATE SURVEY COMPLETED
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
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F 609 SS=D	"within 5 working day On 10/25/18 at 8:54 conducted with ASM be clear, I did not represent the event after On 10/25/18 at 12:47 administrator, ASM # #3, the assistant administration (Director of Nursing) director were all made concerns. The facility policy title documents in part, the alleged violations and be reported to the Stother required agency Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In response to the stother required agency (ER): 483.12(c)(1) §483.12(c) In response to the stother required agency (ER): 483.12(c)(1) §483.12(c) In response to the stother required agency (ER): 483.12(c)(1) §483.12(c) In response to the stother required agency (ER): 483.12(c)(1) §483.12(c)(1) Ensure (ER): 483.12(c)(1) Ensure (ER): 483.12	e agency, ASM #3 stated, ys." a.m., further interview was #3. ASM #3 stated, "Just to port just because she is eport because she could not I asked her about it." 7 p.m., ASM #1, the senior #2, the administrator, ASM ministrator, ASM #4, the other or, ASM #5, the DON and ASM #4, the medical le aware of the above ed, "Abuse Prevention," her following: "Reporting: All disubstantiated incidents will atte Agency and to other ites" Violations (4) se to allegations of abuse, or mistreatment, the facility ethat all alleged violations	F6	07		12/1/18
	are reported immedia hours after the allega that cause the allega serious bodily injury,	priation of resident property, ately, but not later than 2 ation is made, if the events tion involve abuse or result in or not later than 24 hours if e the allegation do not involve				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE S COMPL	
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WESTPOR	T REHABILITATION	AND NURSING CENTER		7300 FOREST AVE		
	THE THE STERN COLUMN	THE HOROLITO CENTER		RICHMOND, VA 23226		
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F 609	Continued From p	age 26	F 6	609		
	abuse and do not the administrator of officials (including adult protective se for jurisdiction in lo	result in serious bodily injury, to of the facility and to other to the State Survey Agency and rvices where state law provides ong-term care facilities) in tate law through established				
	investigations to the designated repressing accordance with Significant survey Agency, with incident, and if the appropriate correct This REQUIREMED by: Based on resident facility document review, it was determined to report an allegation.	ort the results of all the administrator or his or her centative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. INT is not met as evidenced the interview, staff interview, eview, and clinical record formined that facility staff failed ation of abuse to the ties for one of 46 residents in the Resident #23.		1. Corrective Action The Facility Reported Inc. # 23's allegation of abuse the Office of Licensure at on 11/16/18.	e was faxed to	
	agencies, Resider made to this writer administrator on 1 The findings include Resident #23 was 6/24/16 with diagn limited to Parkinson muscles, difficulty dementia, high blodisorder, and type most recent MDS			2. Other Potential Reside Any resident that has an abuse, neglect, exploitati mistreatment has the pot affected. The facility's As Administrator of Clinical re-educated on 11/15/18 Administrator on requirer reporting abuse allegatio 3. Systemic Changes Any allegations of abuse exploitation or mistreatm	allegation of ion or tential to be sistant Services was by the ments of ns.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION		(X3) DATE S COMPL	
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F 609	Resident #23 was co impaired in cognitive on the BIMS (Brief In exam. Resident #23 dependence on one spersonal hygiene, an assistance with two obed mobility, and trarcoded in Section B (FVision), as sometime sometimes being undocommunication. On 10/23/18 at 3:30 pconducted with Residinterview, Resident # had hit her with a stick the woman as "the woman as "the woman was her room" No." When asked woman was her room "No." When asked woman was her room "No." When asked woman was her room handle. Resident #23 stated to broom handle. Resident #23 stated to broom handle at 2 AM the stated that she had not had it probably "some handle woman was her room and that it probably "some handle woman was her room and that it probably "some handle woman was her room and that it probably "some handle woman was her room and that it probably "some handle woman was her room and that it probably "some handle woman was her room and that it probably "some handle woman was her room and that it probably "some handle woman was her room and that it probably "some handle woman was her room woman was her room "No." When asked woman was her room "No." When	ded as being severely function scoring 05 out of 15 derview for Mental Status) was coded as requiring total staff member with dressing, d bathing; and extensive or more staff members with desfers. Resident #23 was dearing, Speech, and is understanding others and derstood by others for some interview was dent #23. During the 23 had alleged that a woman k. Resident #23 identified for or ecall her name. Resident he woman had then gone dis. When asked if this simulate, Resident #23 stated, that kind of stick was used, that is was the end of a dent #23 stated that it at morning. Resident #23 of reported this to anyone should be looked at." that she still felt safe at the some, this allegation was ministrative staff member) ASM #2 stated that she de situation.	F 60	reported to the Administrator to state agencies according the federal regulations and in active facility's abuse policy. Et 11/15/18 the facility Administ report all allegations of abuse exploitation or mistreatment at the internal investigation. The QAPI Committee will revisacility's Grievance Log week to validate any potential abuse if applicable was completed in with the regulations. 4. Monitoring The results of all audits will be to the QAPI Committee for recommendations. 5. Date of compliance 12/1/18	to state and cordance we fective wrater will e, neglect, and initiate wiew the kly x 3 months accordance for warden	ths g, nce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	O NURSING CENTER		STREET ADDRESS, CITY, STATE, 17300 FOREST AVE RICHMOND, VA 23226	ZIP CODE	
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F 609	Resident #23 and her recall the above alleg witness statements. On 10/25/18 at 8:37 at (facility reported incid ASM #3. ASM #3 states at FRI because she im Resident #23 on 10/2 no recollection of her #3 stated that Reside confusion. ASM #3 st Resident #23 and her and again that morning stated that Resident #3 after at the facility dur #3 stated that she has the investigation the cowho was responsible stated that she was. As the investigation the cowho was responsible stated that she was. As the process was to report window to the appropriated that during this also investigating the again that she did not allegation because Responsible to the appropriate that during the again that she did not allegation because Responsible to the appropriate that during the again that she did not allegation because Responsible to the appropriate that the roommate was also stated that no on 2 AM. When asked we will be above the appropriate that the roommate was also stated that no on 2 AM. When asked we will be above the appropriate that the roommate was also stated that no on 2 AM. When asked we will be above the appropriate that the roommate was also stated that no on 2 AM. When asked we will be above the appropriate that the roommate was also stated that no on 2 AM. When asked we will be above the appropriate that the roommate was also stated that no on 2 AM.	ximately 5 p.m., ted witness statements from roommate. Neither could ation according to the a.m., a copy of the FRI ent) was requested from ted that she did not submit amediately went in to talk to 3/18, and the resident had allegation being made. ASM at 23 had periods of ated that she had talked to roommate twice that day, ag (10/24/18). ASM #3 #23 had stated that she felt ing her investigation. ASM db brought this writer a file of day before. When asked for reporting abuse, ASM #3 When asked that typically the abuse within a 2-hour riate agencies. ASM #3 two-hour window, she is allegation. ASM #3 stated areport Resident #23's esident #23 had no e hitting her in the head with estigation. ASM #3 stated as alert and oriented and e had come into the room at when a follow up report to the office, ASM #3 stated,	F	509		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 622 SS=E	conducted with ASM be clear, I did not reconfused. I did not reconfused. I did not reconfused. I did not recall the event afte. On 10/25/18 at 12:4 administrator, ASM #3, the assistant administrat (Director of Nursing director were all maconcerns. Facility policy titled, documents in part, the alleged violations are be reported to the Stother required agent Transfer and Dischator CFR(s): 483.15(c)(1) Facility (i) The facility must be remained in the facility discharge the resider (A) The transfer or confused in the company of the resident sufficiently so the reservices provided by (C) The safety of incompany of the resider status of the resider statu	a.m., further interview was 1 #3. ASM #3 stated, "Just to port just because she is eport because she could not r I asked her about it." 7 p.m., ASM #1, the senior #2, the administrator, ASM ministrator, ASM #4, the other tor, ASM #5, the DON and ASM #4, the medical de aware of the above "Abuse Prevention," he following: "Reporting: All and substantiated incidents will tate Agency and to other cies" Inge Requirements (i)(i)(i)(2)(i)-(iii) and discharge-ty requirements-permit each resident to and not transfer or ent from the facility unless-lischarge is necessary for the and the resident's needs a facility; lischarge is appropriate and the facility; dividuals in the facility is the clinical or behavioral		622			12/1/18

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 622	appropriate notice, under Medicare or Nonpayment applie submit the necessary payment or after the Medicare or Medicare or Medicare or Medicare or Medicare or Medicare or Medicaresident refuses to resident who beconsumed and in the facility or the facility may resident while the as \$431.230 of this continuous of the facility. The facility or safety of the restacility. The facility that failure to transing facility that failure to transing facility that facility that facility the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility or discharge is door medical record and communicated to the facility of the facilit	as failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. The sifthe resident does not any paperwork for third party the third party, including aid, denies the claim and the pay for his or her stay. For a mes eligible for Medicaid after lity, the facility may charge a table charges under Medicaid; asses to operate. The not transfer or discharge the appeal is pending, pursuant to thapter, when a resident ar right to appeal a transfer or to the facility pursuant to the facility pursuant to the facility pursuant to the would endanger the health dident or other individuals in the facility must document the danger fer or discharge would pose. The not transfer or discharge the appeal is pending, pursuant to the facility pursuant t	F	622			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
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F 622	section, the specific be met, facility atterneeds, and the ser facility to meet the (ii) The documenta (2)(i) of this section (A) The resident's discharge is necess (A) or (B) of this section. (B) A physician who necessary under post this section. (iii) Information promust include a min (A) Contact information promust include a min (C) Advance Direct (D) All special instrongoing care, as a (E) Comprehensive (F) All other necessions (F) All other necessions of the resident consistent with §48 any other document a safe and effective This REQUIREME by: Based on staff into and clinical record facility staff failed to paperwork was prothe time of transfer	paragraph (c)(1)(i)(A) of this coresident need(s) that cannot empts to meet the resident vice available at the receiving need(s). Ition required by paragraph (c) in must be made by-physician when transfer or sary under paragraph (c) (1) ection; and en transfer or discharge is aragraph (c)(1)(i)(C) or (D) of evided to the receiving provider imum of the following: ation of the practitioner care of the resident. Sentative information including in tive information ructions or precautions for ppropriate.	F 62	1.Corrective Action Resident # 73 returned from th on 8/10/18. Providing Care pla the hospital is no longer neces Resident # 51 returned form th on 10/17/18. Providing Care pl	n goals to sary.	
	1. The facility staff	failed to evidence that the		the hospital is no longer neces		

F 622 Continued From page 32 F 622 comprehensive care plan goals were sent with Resident #73 upon transfer to the hospital on 8/6/18. 2. The facility staff failed to evidence the comprehensive care plan goals were sent with Resident # 51 upon transfer to the hospital on 9/20/18. Providing required documentation and information to the hospital is no longer necessary.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
MESTPORT REHABILITATION AND NURSING CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Comprehensive care plan goals were sent with Resident #73 upon transfer to the hospital on 8/6/18. 2. The facility staff failed to evidence the comprehensive care plan goals were sent with Resident #51 upon transfer to the hospital on Resident #52 returned from the hospital Resident #52 returned from the hospital on Resident #52 returned from the hospital Resident #53 returned from the hospital Resident #54 returned from the Resident #55 returned from the Resident #55 returned f			495227	B. WING _			10/25/2018	
F 622 Continued From page 32 comprehensive care plan goals were sent with Resident #73 upon transfer to the hospital on 8/6/18. 2. The facility staff failed to evidence the comprehensive care plan goals were sent with Resident # 51 upon transfer to the hospital on 8/6/18. REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 622 REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 622 Resident # 52 returned from the hospital on 9/20/18. Providing required documentation and information to the hospital is no longer necessary.			AND NURSING CENTER	•	7300 FOREST AVE			
comprehensive care plan goals were sent with Resident #73 upon transfer to the hospital on 8/6/18. Resident # 52 returned from the hospital on 9/20/18. Providing required documentation and information to the comprehensive care plan goals were sent with Resident # 51 upon transfer to the hospital on	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETION	
9/10/18 and 9/21/18. 3. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 09/16/18 for Resident # 52. 4. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 10/14/18 for Resident # 158. 5. The facility staff failed to evidence that the comprehensive care plan goals for Resident # 117 were sent to the receiving facility for a hospital transfer on 09/05/18. 6. The facility staff failed to evidence that the comprehensive care plan goals for Resident # 114 were sent to the receiving facility for a hospital transfer on 09/21/18. The findings include: 1. The facility staff failed to evidence that the comprehensive care plan goals were sent with Resident #73 upon transfer to the hospital on 8/6/18. Resident # 158 returned from the hospital on the same day that she was sent to the ER, 10/14/18. Providing required documentation and information to the hospital is no longer necessary. Resident # 117 returned from the hospital on 9/18/18. Providing Care plan goals to the hospital is no longer necessary. Resident # 117 returned from the hospital on 9/18/18. Providing Care plan goals to the hospital is no longer necessary. Licensed nurses responsible for transferring residents to the hospital were re-educated on 10/28/18 regarding all information that must be sent with the resident to the receiving provider including, but not limited to the following: Contact information, All special instructions or preautions for ongoing care, as appropriate, Comprehensive care plan goals; All other necessary information, including a copy of the resident's discharge summary.	F 622	comprehensive ca Resident #73 upor 8/6/18. 2. The facility staff comprehensive ca Resident # 51 upo 9/10/18 and 9/21/1 3. The facility staff required document provided to the redicility-initiated train # 52. 4. The facility staff required document provided to the redicility-initiated train # 52. 5. The facility staff comprehensive ca were sent to the retransfer on 09/05/1 6. The facility staff comprehensive ca were sent to the retransfer on 09/21/1 The findings included the facility staff comprehensive ca were sent to the retransfer on 09/21/1 The facility staff comprehensive ca Resident #73 upor	re plan goals were sent with a transfer to the hospital on failed to evidence the re plan goals were sent with a transfer to the hospital on 8. failed to evidence that all tation and information was reiving provider for a resident failed to evidence that all tation and information was reiving provider for a resident failed to evidence that all tation and information was reiving provider for a resident failed to evidence that the re plan goals for Resident #117 receiving facility for a hospital 8. failed to evidence that the re plan goals for Resident #114 receiving facility for a hospital 8. failed to evidence that the re plan goals for Resident #114 receiving facility for a hospital 8.	F6	Resident # 52 returned from on 9/20/18. Providing requi documentation and informat hospital is no longer necess. Resident # 158 returned from the same day that she well ER, 10/14/18. Providing reducted documentation and informat hospital is no longer necess. Resident # 117 returned from on 9/18/18. Providing Care the hospital is no longer necess. Resident # 114 returned from on 9/25/18. Providing Care the hospital is no longer necess. Licensed nurses responsible transferring residents to the re-educated on 10/29/18 reginformation that must be ser resident to the receiving profincluding, but not limited to a Contact information of the presponsible for the care of the Resident representative information. Directive information, All sprinstructions or precautions from the care, as appropriate, Compiplan goals; All other necess information, including a coperesident's discharge summatical contacts informatical contacts information, including a coperesident's discharge summatical contacts informatical contacts infor	ired tion to the sary. In the hospital ras sent to the quired tion to the sary. In the hospital plan goals to cessary. In the hospital plan goals to cessary.		

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F 622	12/12/97, with rece with diagnoses that to: cerebral palsy [I control due to perm damage occurring I (1)], urinary retentic disorder characteriz difficulty in breathin mucus production, bronchi. (2)], and re [inadequate amour blood. (3)]. The most recent M assessment, a qua assessment referer resident as being ir state/no discernabl. The nurse's note didocumented in part related to noted au (shortness of breat elevated temp (term condition started or started, it has gotte Emergency transferecommendations in person was notified (sic)." The physician orde "Send to ER (emer (evaluation)." Furth failed to evidence a resident's compreh	admitted to the facility on int readmission on 8/10/18, included but were not limited oss or deficiency of muscle nanent, nonprogressive brain before or at the time of birth. On, asthma [respiratory ized by recurrent episodes of ag, wheezing, cough, and thick caused by inflammation of the espiratory failure with hypoxia at of available oxygen in the	F 62	Any resident who has been to the hospital has the potential affected. A 50% audit was co 11/12/18 for all residents that sent to the hospital over the pmonths. For any resident that the required information sent the hospital or documentation clinical record that the require information was sent with the licensed nurse responsible w counseled. 3.Systemic Changes A 50% audit will be completed months for all residents that a transferred to the hospital to the required information was resident to the hospital and d in the clinical record. Any are non-compliance will be imme corrected and responsible state counseled. 4.Monitoring The results of all audits will be to the QAPI Committee for refrecommendations. 5.Date of compliance	to be mpleted of have bee past 3 t did not h with them in the ed resident, as ly weekly are validate th sent with ocumente as of diately aff will be	n n ave to the at	

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F 622	practical nurse) # regarding what is resident is transfer following go with Capabilities List (home can provide Copy of Medicationew medications, Discharge form, at the care plan was them (residents). of the Notice of TLPN #6 stated, "I We also send the there have been instituted an action regulation. It's new The "QA (quality received on 10/25 (administrative stadministrator. The The Action Plan of	conducted with LPN (licensed 6 on 10/25/18 at 10:28 a.m., sent to the hospital when a erred. LPN #6 stated the the resident: Nursing Home a list of services the nursing e) Transfer form, Face sheet, on List - updated with changes of Notice of Transfer and end Care plan. LPN #6 stated as something new that goes with When asked if they keep copies ransfer and Discharge Form, would but not sure if it's needed. The bed hold policy." LPN #6 stated changes recently and they have on plan to follow the new we to send the care plan." assurance) Action Plan was 5/18 at 11:10 a.m. from ASM aff member) #3, the assistant e Action Plan was dated 9/1/18. documented in part, "Factors	F 6				
	The Action Plan documented in part, "Factors identified in root cause analysis of this issue - Through chart review it was noted that residents' did not have complete documentation of all paperwork that was sent with or given to resident when being transferred to the hospital for evaluation. Actions planned: Licensed Nurses will be Re-educated on the importance of accurate documentation of all documents that are sent with resident to the hospital including but not limited to POS (physician order summary), Capabilities List, and transfer form with reason for transfer, bed hold policy and care plan."						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED	
		495227	B. WING _	 		10/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	is to be sent with the the hospital. ASM (administrativ administrator), ASM administrator), ASM administrator), ASM administrator), ASM and ASM #6 (the maware of the above p.m. ASM #3 state evidence that the cosent with the reside No further informat (1) Barron's Diction Non-Medical Readd Chapman, page 11 (2) Barron's Diction Non-Medical Readd Chapman, page 51 (3) Barron's Diction Non-Medical Readd Chapman, page 28 2. The facility staff comprehensive car	documentation related to what the resident being transferred to the estaff member) #2 (the M #3 (the assistant M #4 (another assistant M #5 (the director of nursing) hedical director) were made to concern on 10/25/18 at 12:41 at the facility did not have any comprehensive care plan was ent upon discharge. It is any of Medical Terms for the er, 5th edition, Rothenberg and	F 6	,			
	8/29/18 with a mos 9/17/18, with diagn not limited to: strok fibrillation [a conditi random contraction	admitted to the facility on trecent readmission on oses that included but were e, high blood pressure, atrial on characterized by rapid and of the atria of the heart eats of the ventricles and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	.ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODI 7300 FOREST AVE RICHMOND, VA 23226		•	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	clot formation in the peripheral vascular condition, including blood vessels outsi presence of prosthe. The most recent Mi assessment, a Med with an assessment coded the resident (brief interview for the is moderately in decisions. Review of the nurse #51 was transferred 9:20 a.m. Further refailed to evidence a residents comprehe provided to the recentransfer on 9/10/18 An interview was comprehed provided to the recentral nurse) #6 regarding what is some resident is transferred following go with the Capabilities List (a home can provide) Copy of Medication new medications, Noischarge form, and the care plan was some them (residents). Wo of the Notice of Trail LPN #6 stated, "I we we also send the base of the service of the Notice o	deed heart output and frequently atria. (1)], heart failure, disease [any abnormal atherosclerosis, affecting de the heart. (2)], and etic heart valve. DS (minimum data set) licare five day assessment, the reference date of 9/21/18, as scoring a "7" on the BIMS mental status) score, indicating apaired to made daily cognitive des notes revealed Resident destroyed to the hospital on 9/10/18 at eview of the clinical recording documentation the ensive care plan goals were eviving hospital at the time of	F 6	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	regulation. It's new to The QA (quality ass received on 10/25/1 (administrative staff administrator. The A Resident #51 was donot having the transclinical record for 9/ASM (administrator), ASM administrator), ASM administrator), ASM administrator), ASM administrator), ASM administrator), ASM and ASM #6 (the meaware of the above p.m. ASM #3 the faction with the resident with the resident (1) Barron's Dictiona Non-Medical Reade Chapman, page 55. (2) Barron's Dictiona Non-Medical Reade Chapman, page 447. 3. The facility staff for required documental provided to the recefacility-initiated transfers. Resident # 52 was a 05/23/18 with diagninot limited to: dysphonot limited to:	colan to follow the new to send the care plan." Surance) Action Plan was 8 at 11:10 a.m. from ASM member) # 3, the assistant action Plan was dated 9/1/18. Occumented on the QA plan as fer documentation in the 10/18 transfer to the hospital. Se staff member) #2 (the #3 (the assistant #4 (another assistant #5 (the director of nursing) edical director) were made concern on 10/25/18 at 12:41 cility did not have any emprehensive care plan was not upon discharge. Surary of Medical Terms for the result of the plan was not upon discharge. Surary of Medical Terms for the result of the plan was not upon discharge. Surary of Medical Terms for the result of the plan was not upon discharge. Surary of Medical Terms for the result of the plan was not upon discharge. Surary of Medical Terms for the result of the plan was not upon discharge and was not upon discharge and result of the plan was	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495227	B. WING		1	0/25/2018	
	ROVIDER OR SUPPLIER	ID NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	Resident # 52's mos set), a quarterly asset (assessment referent Resident # 52 as socinterview for mental - 15, 7 (seven) - beir cognition for making The nurse's "Progres dated 09/16/2018 "1 condition noted relations as the complete set of the c	t recent MDS (minimum data essment with an ARD ce date) of 09/06/18, coded oring a 7 (seven) on the brief status (BIMS) of a score of 0 ng severely impaired of daily decisions.	F 62	22			
	Review of the clinical failed to the evidence was provided to the Resident # 52's trans 09/16/2018. There we Resident # 52's cont practitioner responsi resident; resident rejincluding contact information, all specifor ongoing care, as	It record for Resident # 52 re required documentation receiving facility at the time of refer to the hospital on reas no evidence, that react information of the ble for the care of the resentative information remation, Advance Directive real instructions or precautions repropriate, comprehensive other necessary information					
	conducted with ASM member) # 3, assists asked to provide doc 52's contact informative responsible for the conformation, Advance special instructions coare, as appropriate.	a p.m., an interview was (administrative staff ant administrator. When cumentation that Resident # tion of the practitioner are of the resident, resident nation including contact the Directive information, all or precautions for ongoing the comprehensive care plan ssary information, including a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	l ' '	E SURVEY PLETED
		495227	B. WING		10	/25/2018
	ROVIDER OR SUPPLIER	AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		·	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 622	provided to the rec Resident # 52's tra 09/16/2018, ASM # anything regarding On 10/25/18 at app (administrative stafadministrator and A administrator, ASM ASM # 5 director of medical director we findings. No further informat References: (1) A swallowing disobtained from the well- https://www.nlm.nih.sorders.html. (2) High blood presobtained from the well- https://www.nlm.nih.essure.html. (3) A stroke. When brain stops. A strokattack." If blood flot few seconds, the boxygen. Brain cells damage. This infort website: https://medlineplus	t's discharge summary was eiving facility at the time of insfer to the hospital on a stated, "We don't have the resident's transfer." broximately 12:45 p.m., ASM of member) # 2, the ASM # 2, assistant administrator, for nursing and ASM # 6, are made aware of the dison was provided prior to exit. sorder. This information was website: in.gov/medlineplus/swallowingdiesure. This information was	F 62	2		
	Quadriplegia. Para	alysis is the loss of muscle rour body. It happens when				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018	
	ROVIDER OR SUPPLIER	ID NURSING CENTER	·	STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	pass between your becan be complete or pot both sides of your become area, or it can be information was obtat https://medlineplus.g 4. The facility staff for required documentat provided to the receifacility-initiated trans: # 158. Resident # 158 was : 06/26/17 with diagnor not limited to: heart for disorder (2), anemia pulmonary disease (4). Resident # 158's modata set), a quarterly (assessment referent Resident # 158 as so interview for mental serior - 15, 13 - being cognidecisions. Resident requiring extensive a member for all activity. The nurse's "Progress documented, "10/14/condition noted related of burning at 7:30 a.r. cool clammy, slow to hospital."	ng with the way messages brain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just the widespread This ined from the website: ov/paralysis.html. alled to evidence that all ion and information was ving provider for a fer on 10/14/18 for Resident admitted to the facility on sees that included but were aillure (1), depressive (3) and chronic obstructive 4). st recent MDS (minimum rassessment with an ARD ce date) of 10/11/18, coded coring a 13 on the brief status (BIMS) of a score of 0 itively intact for making daily # 158 was coded as ssistance of one staff	F	522			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 622	Resident # 158's tra 10/14/2018. There we 158's contact inform responsible for the corepresentative inform information, Advance special instructions of care, as appropriate goals, all other necest copy of the resident's sent to the hospital. On 10/25/18 at appreciation (administrative staff administrator and Assadministrator, were documentation that provided to the recest Resident #158's transfer." On 10/25/18 at appreciation (administrator) at the resident's transfer." On 10/25/18 at appreciation (administrator) and Assadministrator and Assadmin	iving facility at the time of insfer to the hospital on was no evidence Resident # ation of the practitioner are of the resident, resident mation including contact in a Directive information, all per precautions for ongoing incomprehensive care plan in sary information, including a significant state of the same and the same are stated to provide all required documents were saving hospital at the time of insfer to the hospital on the same and the same and the same and the same are same are same and the same are same and the same are same are same are same are same and the same are	F 6	22		
	efficiently. This caus	a blood to the rest of the body ses symptoms to occur . This information was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/25/2018
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	(2) Depression may blue, unhappy, miss Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This information website: https://medlineplus. (3) Low iron. This in the website: https://www.nlm.nih (4) Disease that macan lead to shortne was obtained from https://www.nlm.nih 5. The facility staff is comprehensive can were sent to the rectansfer on 09/05/13. Resident #117 was 02/24/18. Her diagr Vascular Accident (Dysphagia (difficulty speaking) Disorder. The Brief	website: gov/ency/article/000158.htm. be described as feeling sad, erable, or down in the dumps. way at one time or another for cal depression is a mood delings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. Information was obtained from a.gov/medlineplus/anemia.html akes it difficult to breath that as of breath. This information the website: a.gov/medlineplus/copd.html. Failed to evidence that the e plan goals for Resident #117 beiving facility for a hospital 8. admitted to the facility on noses included Cerebral Stroke), Muscle Weakness, y swallowing), Aphasia a, and Major Depressive Interview for Mental Status	F 62	22		
	comprehensive can were sent to the rec transfer on 09/05/15 Resident #117 was 02/24/18. Her diagr Vascular Accident (Dysphagia (difficult (difficulty speaking)) Disorder. The Brief (BIMS) scored Res minor impairment. I Data Set (MDS) As	e plan goals for Resident #117 ceiving facility for a hospital 8. admitted to the facility on noses included Cerebral Stroke), Muscle Weakness, y swallowing), Aphasia , and Major Depressive Interview for Mental Status ident #117 at 13, indicating Her most recent Minimum sessment was a Significant int with an Assessment				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	*	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	conducted on 10/24 Resident #117 was 09/05/18 following a progress note dated reads: "911 in at thi [HOSPITAL]. All pa driver. Hospital upd arrival. RP made av While the note desc ambulance driver", as to what that pape An interview was co practical nurse) # 6 When asked what p hospital when a res stated the following Nursing Home Cap the nursing home c Face sheet, Copy of with changes of new Transfer and Discha LPN #6 stated the of that goes with them keeps copies of the Discharge Form, LF sure if it's needed. N policy." LPN #6 stat recently and they ha follow the new regular care plan." The Administrator, a member) #1 and As were informed of the	at #117's record was 1/18. It was noted that 1/18. It	F	622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	•		
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F 622	Continued From pa	ge 44	F 622	2			
	comprehensive care	ailed to evidence that the plan goals for Resident #114 eiving facility for a hospital					
	facility on 01/08/16. was 09/25/18. His of (1), Cerebral Vascul Hemiplegia (weakned Dysphagia (difficulty (difficulty speaking), Diabetes Mellitus Tyexcessive levels of (2), Atrial Fibrillation The most recent ME Assessment was a Assessment with an date) of 10/09/18. T	originally admitted to the His most recent re-admission diagnoses included Sepsis ar Accident (Stroke), ess on one side of the body), ess wallowing), Aphasia Urinary Tract Infection, epe II (a condition causing sugar in the blood), Epilepsy (3), and Heart Failure (4). DS (minimum data set) M4-Day Admission ARD (assessment reference the BIMS scored Resident g moderate impairment.					
	had been discharge A progress note date reads: "(Name of an Ambulance here at [HOSPITAL] via streatment. RP (resp was no documentati	nt #114's record revealed he d to the hospital on 09/21/18. ed 09/21/18 at 10:00 p.m.,. hbulance company) this time to take resident to tcher for evaluation and possible party) aware." There on of what, if anything, was not to the emergency room.					
	practical nurse) # 6 When asked what p hospital when a resi stated the following Nursing Home Capa	nducted with LPN (licensed on 10/25/18 at 10:28 a.m. aper work is sent to the dent is transferred, LPN #6 go with the resident: abilities List (a list of services an provide), Transfer form,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	with changes of new Transfer and Dischale LPN #6 stated the country that goes with them keeps copies of the Discharge Form, LF sure if it's needed. A policy." LPN #6 state recently and they had follow the new regular care plan." The Administrator, A member) #1 and AS were informed of the meeting on 10/25/18 was provided. 1. Sepsis is a seriou your body has an oversponse to a bacter released into the blood clots and leak poor blood flow, whorgans of nutrients a one or more organs pressure drops and septic shock. This in the website: https://	Medication List - updated with medications, Notice of arge form and Care plan. are plan was something new. When asked if the facility Notice of Transfer and Min #6 stated,"I would but not We also send the bed hold ed there have been changes are instituted an action plan to ation. It's new to send the Machine Min #2, Director of Nursing e findings at the end of day 3. No further documentation with line infection. The chemicals and to fight the infection inflammation. This leads to be and oxygen. In severe cases, fail. In the worst cases, blood the heart weakens, leading to information was obtained from medlineplus.gov/sepsis.html	F 6	22		

i ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	730	REET ADDRESS, CITY, STATE, ZIP CODE 10 FOREST AVE CHMOND, VA 23226		
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F 622	obtained from the whttps://medlineplus. 3. An arrhythmia is rhythm of the hearth the most common the can lead to an increpatients, it can also attack, or heart failure obtained from the whttps://medlineplus. 4. Heart failure is a can't pump enough needs. Heart failure heart has stopped comeans that your hearth as stopped comeans that your hearth way it should. It of the heart. The we pumping ability cause up into the lungs, Thankles and legs - cashortness of breathfailure are coronary pressure and diabeted obtained from the whttps://medlineplus. 5. Rigors are episod rises - often quite quishivering accompare ('the chills'). The few shivering may be quinformation was obth https://patient.info/h	ss This information was ebsite: gov/epilepsy.html a problem with the speed or peat. Atrial fibrillation (AF) is type of arrhythmia. The cause heart's electrical system. AF ased risk of stroke. In many cause chest pain, heart re This information was ebsite: gov/atrialfibrillation.html condition in which the heart blood to meet the body's does not mean that your or is about to stop working. It fart is not able to pump blood can affect one or both sides eakening of the heart's sees: Blood and fluid to back the buildup of fluid in the feet, alled edema, Tiredness and Common causes of heart artery disease, high blood tes This information was ebsite: gov/heartfailure.html les in which your temperature wickly - whilst you have severe sided by a feeling of coldness ter may be quite high and the lite dramatic This ained from the website:		622			12/1/18
. 020		2 20.0.0	'				, .,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DE		
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F 623 SS=E			F 62	23			
	§483.15(c)(3) Notice Before a facility trans resident, the facility r (i) Notify the resident representative(s) of the reasons for the manuage and representative of the Long-Term Care Om (ii) Record the reasond discharge in the residence with paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specific (c)(8) of this section, discharge required under by the facility aresident is transferre (ii) Notice must be modern before transfer or dis (A) The safety of indibe endangered under this section; (B) The health of indibe endangered, under this section; (C) The resident's heallow a more immediate transfer paragraph (c)(D) An immediate transfer transfer transfer transfer or dis (C) The resident's heallow a more immediate transfer	before transfer. sfers or discharges a must- and the resident's he transfer or discharge and hove in writing and in a er they understand. The copy of the notice to a Office of the State budsman. Ins for the transfer or dent's medical record in agraph (c)(2) of this section; lice the items described in his section. If of the notice. If in paragraphs (c)(4)(ii) and the notice of transfer or noder this section must be at least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would ar paragraph (c)(1)(i)(C) of ividuals in the facility would ar paragraph (c)(1)(i)(D) of ealth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIF 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 623	(E) A resident has days. §483.15(c)(5) Connotice specified in must include the formal include the formal include the formal including the name and telephone nurreceives such requite obtain an appear completing the formal including the name, and telephone number Long-Term Care Completing the formal including the name, and telephone number Long-Term Care Completing the formal including	tents of the notice. The written paragraph (c)(3) of this section ollowing: transfer or discharge; ate of transfer or discharge; which the resident is harged; the resident's appeal rights, e, address (mailing and email), niber of the entity which uests; and information on how all form and assistance in m and submitting the appeal ress (mailing and email) and of the Office of the State ombudsman; cility residents with intellectual all disabilities or related illing and email address and of the agency responsible for advocacy of individuals with abilities established under Part tental Disabilities Assistance act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the efor the protection and duals with a mental disorder the Protection and Advocacy	F	623			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		10/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	, .0.20.20.0
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 623	Continued From pag §483.15(c)(6) Chang If the information in t effecting the transfer must update the reci as practicable once t becomes available. §483.15(c)(8) Notice In the case of facility the administrator of t written notification proto the State Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residence in the state Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residence in the state Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residence in the state of the s	e 49 es to the notice. he notice changes prior to or discharge, the facility pients of the notice as soon he updated information in advance of facility closure closure, the individual who is he facility must provide ior to the impending closure agency, the Office of the re Ombudsman, residents of resident representatives, as he transfer and adequate dents, as required at § It is not met as evidenced	F 62	DEFICIENCY)	ospital
	initiated transfer for r survey sample, Resident 117, #114, #83, #10 1. The facility staff far notification to the resident and far ombudsman for a fact Resident #73 on 8/6/2. The facility staff far notification to the resident representative and fact representative and fact resident #73 on 8/6/2.	iled to provide written ident and/or resident ailed to notify the cility initiated transfer for 18. iled to provide written ident and/or resident ailed to notify the cility initiated transfer for		to the resident and/or resident representative is no longer applicated. Resident # 51 returned form the hon 10/17/18. Providing written not to the resident and/or resident representative is no longer applicated. Resident #52 returned from the hon 9/20/18. Providing written not to the resident and/or resident representative is no longer applicated. Resident #158 returned from the hon the same day that she was ser ER, 10/14/18. Providing written	ospital ification able. ospital fication able.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495227	B. WING _			10/	/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	•	
WEGTDOE	T DELLA DIL ITATIONI ANI	NURSING CENTER		730	00 FOREST AVE		
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER		RIG	CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	e 50	F 6	23			
	2. The facility staff fail	lad ta pravida Basidant # 52			notification to the resident and/or reside	ent	
	or the resident's repre	led to provide Resident # 52			representative is no longer applicable.		
		otification when the resident			Resident #117 returned from the hospi	tal	
		hospital on 09/16/18.			on 9/18/18. Providing written notification		
					to the resident and/or resident		
	4. The facility staff fail	led to provide Resident #			representative is no longer applicable.		
		representative and the					
		otification when the resident			Resident #114 returned from the hospi		
	was transferred to the	hospital on 10/14/18.			on 9/25/18. Providing written notification	n	
	E. The facility staff fail	lad to avidonae			to the resident and/or resident		
	The facility staff fail documentation of writ				representative is no longer applicable.		
		ity initiated transfer to the			Resident #83 was discharged home or	1	
	hospital for Resident				10/30/18. Providing written notification		
					the resident and/or resident		
	6. The facility staff fail	led to evidence			representative is no longer applicable.		
	documentation of writ	ten notification to the					
		tative and written notification			Resident #108 was discharged home of		
		r Resident #114's facility			11/15/18. Providing written notification	to	
	initiated transfer to the	e hospital on 09/21/18			the resident and/or resident representative is no longer applicable.		
	7. The facility staff fail	led to provide evidence that			2 J. 18		
		nbudsman was notified of			Resident #133 was discharged home of	n	
	Resident #83's facility	-initiated hospital transfer			10/26/18. Providing written notification	to	
	on 7/25/18.				the resident and/or resident representative is no longer applicable.		
	8. The facility staff fail	led to provide evidence that					
	the long term care on	nbudsman was was notified			The Office of the State Long-Term Care	е	
	of Resident #108's fac	cility-initiated hospital			Ombudsman was notified of the transfe		
	transfer on 10/8/18.				for Residents #73, #51, #52, #158, #11 #114, #83, #108 and #133 on 11/26/18		
		led to provide evidence that					
	_	nbudsman was notified of			Licensed Nurses were re-educated on		
		ty-initiated hospital transfer			10/29/18 on the requirement that the		
	on 9/25/18.				resident or the residents representative must receive written notice of a facility	;	
	The findings include:				initiated transfer to the hospital.		
	go.a.ao.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X3) DATE COMP		
		495227	B. WING		10/25/2	018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2	
			,	7300 FOREST AVE		
WESTPOF	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) MPLETION DATE
F 623	Continued From page	÷ 51	F 623	3		
	1. The facility staff fai notification to the resi representative and fa	led to provide written dent and/or resident iled to notify the ility initiated transfer for		Facility Social Workers were re-education 10/29/18 on the requirement that the ombudsman must receive written notice of a facility initiated transfer to the hos	e e	
	D:-			2.Other Potential Residents		
	12/12/97, with recent with diagnoses that in to: cerebral palsy [los control due to permar damage occurring be (1)], urinary retention disorder characterize difficulty in breathing, mucus production, cabronchi. (2)], and resp [inadequate amount oblood. (3)].	d by recurrent episodes of wheezing, cough, and thick used by inflammation of the biratory failure with hypoxia of available oxygen in the		Residents who have been transferred the hospital have the potential to be affected. A 50% audit was completed on 11/12/for all residents that have been sent to hospital over the past 3 months. For a resident that did not have documentation of written notice of transfer to the resident/resident representative in the clinical record at the time of transfer, the licensed nurse responsible has been counselled.	18 the ny on	
	assessment reference resident as being in a	erly assessment, with an e date of 9/13/18, coded the persistent vegetative		For any resident that did not have documentation that the Office of the St Long-Term Care Ombudsman was		
	state/no discernable o			notified of the transfer, the notification been sent.	nas	
	documented in part, "related to noted audit	ed, 8/6/18 at 11:45 (a.m.) Change in condition noted ble wheezing, gurgling, SOB		3. Systemic Changes		
	elevated temp (tempe condition started on 0 started, it has gotten Emergency transfer to recommendations ma	elevated respirations, erature). This change in 18/06/2018. Since this worse INTERVENTIONS: to hospital. No additional ade Emergency contact in 08/06/2018 at 12:00 AM		Documentation will be reviewed weekl 3 months for all residents' that are transferred to the hospital to validate the written notice was provided to the resident/resident representative at the time of transfer and that notification of transfer has been made monthly to the Office of the State Long-Term Care	nat	
	The physician order of	dated 8/6/18 documented,		Ombudsman. Any areas of non-compliance will be immediately		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495227	B. WING _			10/	25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 800 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	failed to evidence the representative were proceeded facility initiated transform ombudsman was not. An interview was compractical nurse) # 6 or regarding what is ser resident is transferred following go with the Capabilities List (a lishome can provide) To Copy of Medication Lonew medications, No Discharge form, and the care plan was softhem (residents). Who of the Notice of Trans LPN #6 stated, "I wou We also send the best there have been char instituted an action place regulation. It's new to Con 10/25/18 at 12:13 conducted with OSM social worker. When ombudsman was not hospital, OSM # state notifying the ombuds hospital. Only for rour	ency Room) for eval review of the clinical record resident or resident provided written notice of the er on 8/6/18 and that the ified. ducted with LPN (licensed in 10/25/18 at 10:28 a.m., at to the hospital when a diducted. LPN #6 stated the resident: Nursing Home at of services the nursing ransfer form, Face sheet, ist - updated with changes of tice of Transfer and Care plan. LPN #6 stated mething new that goes with en asked if they keep copies after and Discharge Form, all but not sure if it's needed. If hold policy." LPN #6 stated inges recently and they have an to follow the new is send the care plan." In p.m., an interview was (other staff member) #3, the asked if the long-term care ified of acute transfers to the ed, "No, we are not currently man for transfers to the	F 6	523	corrected and the responsible staff will counselled. 4. The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	be	
	Notice" documented provide a resident an	in part, "Our facility shall d/or the resident's sor) with a thirty (30) day					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	· ,	TE SURVEY MPLETED
		495227	B. WING _		_	0/25/2018
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STA 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	the notice will be go but before the tran transfer is necessal and the resident's facility3. The resident's facility	er the following circumstances, iven as soon as it is practicable sfer or discharge: a. The ary for the resident's welfare needs cannot be met in the sident and/or representative will ag for the following information: the transfer or discharge; b. of the transfer or discharge; c. ich the resident is being tharged4. A copy of this notice of the State Long-Term The staff member) #2 (the W #3 (the assistant W #4 (another assistant W #4 (another assistant W #5 (the director of nursing) the concern on 10/25/18 at 12:41 with the staff member of the second of the staff member of the staff member of the second of the staff member of the second of the staff member of the s	F	523		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		1	0/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	S, CITY, STATE, ZIP CODE /E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	8/29/18 with a most 9/17/18, with diagno not limited to: stroke fibrillation [a condition random contraction causing irregular bearesulting in decrease clot formation in the peripheral vascular condition, including a blood vessels outside presence of prosthe. The most recent MD assessment, a Medi with an assessment coded the resident a (brief interview for material heads of the commented in part, related to resident material heads on 9/10 in condition started of Notifications: (name was notified on 9/10 Interventions: Emergency medical recommendations as applied via nasal cal medical services) cal (Name of hospital) for the stroke of the	dmitted to the facility on recent readmission on ses that included but were and high plood pressure, atrial on characterized by rapid and of the atria of the heart ats of the ventricles and ed heart output and frequently atria. (1)], heart failure, disease [any abnormal atherosclerosis, affecting let the heart. (2)], and tic heart valve. OS (minimum data set) care five day assessment, reference date of 9/21/18, as scoring a "7" on the BIMS hental status) score, indicating paired to made daily cognitive ted, 9/10/18 at 9:20 a.m. "Change in condition noted oted to be difficult to arouse, pressure) 78/43. This change on 9/10/18Review and of resident representative) //2018 at 9:15 a.m gency transfer to hospital. transportation. Additional is follows: Np (nurse sess, 2 liters of oxygen nnula, EMS (emergency alled, resident transferred to	F 623				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Evaluation." Further failed to evidence the representative were facility initiated trans ombudsman was not an interview was compractical nurse) # 6 regarding what is seresident is transferre following go with the Capabilities List (all home can provide). Copy of Medication new medications, Not Discharge form, and the care plan was set them (residents). Who of the Notice of Trank LPN #6 stated, "I wow we also send the bethere have been chainstituted an action pregulation. It's new to the conducted with OSM social worker. When ombudsman was not hospital, OSM # standtifying the ombuds.	o (Name of Hospital) for review of the clinical record to resident or resident provided written notice of the ster on 9/10/18 and that the stified. Inducted with LPN (licensed on 10/25/18 at 10:28 a.m., ent to the hospital when a resident: Nursing Home st of services the nursing Transfer form, Face sheet, List - updated with changes of otice of Transfer and I Care plan. LPN #6 stated comething new that goes with then asked if they keep copies asfer and Discharge Form, buld but not sure if it's needed. The ded hold policy." LPN #6 stated anges recently and they have belan to follow the new to send the care plan." 3 p.m., an interview was of the care plan." 3 p.m., an interview was of the care plan."	F	623	DEFICIENCY)		
	administrator), ASM administrator), ASM administrator), ASM	staff member) #2 (the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZI 7300 FOREST AVE RICHMOND, VA 23226	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 623	p.m. (1) Barron's Dictional Non-Medical Reader Chapman, page 55. (2) Barron's Dictional Non-Medical Reader Chapman, page 447. 3. The facility staff faor the resident's reprombudsman written was transferred to the Resident # 52 was at 05/23/18 with diagnon to limited to: dysphacerebral infarction (3) Resident # 52's most set), a quarterly asset (assessment referencesident # 52 as socinterview for mental set), 7 (seven) - bein cognition for making The nurse's "Progres dated 09/16/2018 "10 condition noted related unresponsive to taction to the complete the condition of the co	ry of Medical Terms for the , 5th edition, Rothenberg and ry of Medical Terms for the , 5th edition, Rothenberg and ry of Medical Terms for the , 5th edition, Rothenberg and liled to provide Resident # 52 esentative and the notification when the resident e hospital on 09/16/18. Idmitted to the facility on ses that included but were agia (1), hypertension (2), and hemiplegia (4). It recent MDS (minimum data essment with an ARD ce date) of 09/06/18, coded oring a 7 (seven) on the brief status (BIMS) of a score of 0 g severely impaired of daily decisions. Is Notes" for Resident # 52 0:09 a.m. Change in ed to Resident lethargic, le and verbal stimuli.	F6	523	=NCY)	
	representative and the provided written notification was transferred to the	vidence the resident's ne ombudsman were ication when the resident e hospital on 09/16/18. p.m., an interview was				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 623	director of social ser the notification to the Resident # 52 transf 09/16/18, OSM # 3 s confusion of what th ombudsman. We ar ombudsman for tran routine discharges." On 10/25/18 at 1:45 conducted with ASM member) # 3, assista asked to provide doc 52 and Resident # 5 provided with writter 52's transfer to the h # 3 stated, "We don' resident's transfer." On 10/25/18 at appr (administrative staff administrator and AS administrator and AS administrator, ASM # 5 director of medical director wer findings. No further information References: (1) A swallowing discobtained from the we https://www.nlm.nih.sorders.html.	I (other staff member) # 3, vices. When asked about a combudsman regarding er to the hospital transfer on stated, "Initially there was a fax should include to the er not currently notifying the sfers to hospital only for p.m., an interview was (administrative staff ant administrator. When cumentation that Resident # 2's representative were intotification of Resident # 10 cospital on 09/16/2018, ASM at have anything regarding the soximately 12:45 p.m., ASM member) # 2, the SM # 2, assistant # 4 assistant administrator, nursing and ASM # 6, er made aware of the sen was provided prior to exit.	F 62	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		1	0/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 623	essure.html. (3) A stroke. Whe brain stops. A stroke attack." If blood few seconds, the oxygen. Brain cel damage. This infowebsite: https://medlineplu. (4) Also called: He Quadriplegia. Pa function in part of something goes were pass between you can be completed both sides of your one area, or it car information was on https://medlineplu. 4. The facility staft 158 or the resider ombudsman writte was transferred to Resident # 158 were 06/26/17 with diagnot limited to: head disorder (2), an empulmonary disease. Resident # 158's data set), a quarte (assessment referesident # 158 as desident # 158 a	en blood flow to a part of the oke is sometimes called a "brain low is cut off for longer than a brain cannot get nutrients and is can die, causing lasting ormation was obtained from the s.gov/ency/article/000726.htm. emiplegia, Palsy, Paraplegia, ralysis is the loss of muscle your body. It happens when wrong with the way messages ar brain and muscles. Paralysis or partial. It can occur on one or body. It can also occur in just in be widespread. This btained from the website: s.gov/paralysis.html. If failed to provide Resident # int's representative and the en notification when the resident to the hospital on 10/14/18. as admitted to the facility on gnoses that included but were int failure (1), depressive in (3) and chronic obstructive	F	523			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	TE SURVEY MPLETED	
		495227	B. WING _			10/25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 623	- 15, 13 - being cogn decisions. Resident requiring extensive a member for all activit. The nurse's "Progres documented, "10/14/condition noted relate of burning at 7:30 a.r cool clammy, slow to hospital." Further revevidence the residen ombudsman were prowhen the resident was on 10/14/18. On 10/25/18 at 12:11 conducted with OSM director of social servithe notification to the Resident # 158 trans 10/14/18 OSM # 3 st confusion of what the ombudsman. We are ombudsman for trans routine discharges." On 10/25/18 at 1:45 conducted with ASM member) # 3, assistate asked to provide doc 158 and Resident # 158's transfer to the IASM # 3 stated, "We regarding the resident."	itively intact for making daily # 158 was coded as sistance of one staff ies of daily living. Is Notes" for Resident # 158 2018. 11:20 a.m. Change in ed to Resident complaining in. At 10:45 a.m. found to be respond. Transfer to iew of the record failed to it's representative and the ovided written notification is transferred to the hospital p.m., an interview was (other staff member) # 3, vices. When asked about ombudsman regarding fer to the hospital transfer on ated, "Initially there was a fax should include to the enot currently notifying the effers to hospital only for a fax and interview was (administrative staff int administrative staff int administrative were notification of Resident # 158's representative were notification of Resident # 158's representati	F	523			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		10/25/2018
	ROVIDER OR SUPPLIER	AND NURSING CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 623	ASM # 5 director of medical director we findings. No further information of the property of t	aSM # 2, assistant # 4 assistant administrator, for nursing and ASM # 6, ere made aware of the fon was provided prior to exit. Thich the heart is no longer able the blood to the rest of the body ses symptoms to occur y. This information was vebsite: agov/ency/article/000158.htm. If be described as feeling sad, the erable, or down in the dumps. If way at one time or another for ficial depression is a mood the elings of sadness, loss, anger, the with everyday life for weeks mation was obtained from the agov/ency/article/003213.htm. Information was obtained from The agov/medlineplus/anemia.html Takes it difficult to breath that the set of the body the blood to the rest of the body the blood to the blood t	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		,	10/25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZII 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 623	02/24/18. Her diagnot Vascular Accident (St. Dysphagia (difficulty (difficulty speaking), and Disorder. Her most respond to the Massessment with an analysis (ARD) of 10/04/18. The Status (BIMS) scored indicating minor impact in the Status (BIMS) scored in the Status (BIMS) scored in the Masses in the	dmitted to the facility on ses included Cerebral troke), Muscle Weakness, swallowing), Aphasia and Major Depressive ecent Minimum Data Set was a Significant Change Assessment Reference Date The Brief Interview for Mental It Resident #117 at 13, airment. #117's record was 18. It was noted that ischarged to the hospital on change in condition. A 109/05/18 at 11:18 a.m., 1 in at this time to transport AL]. All paperwork given to espital updated on resident RP made aware. Awaiting the describes "paperwork"	F	523			
	hospital. Only for rou The Administrator, Asmember) #1 and ASM	man for transfers to the tine discharges." SM (administrative staff // #2, Director of Nursing findings at the end of day					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		1	0/25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 623	was provided. 6. The facility staff fadocumentation of writesponsible represent to the ombudsman for initiated transfer to the Resident #114 was of facility on 01/08/16. Hespois (1), Cerebral Hemiplegia (weakned Dysphagia (difficulty (difficulty speaking), Diabetes Mellitus Typexcessive levels of second facility on 01/08/16. Hemiplegia (weakned Dysphagia (difficulty (difficulty speaking), Diabetes Mellitus Typexcessive levels of second facility of the most recent MDS As Admission Assessment The BIMS (brief interscored Resident #11 impairment. A Review of Resident had been discharged A progress note date reads: "(Name of am Ambulance here at the IHOSPITAL) via street treatment. RP (respowas no documentation sent with the resident There was no documbeing given to the resident to the resident progress of the re	iled to evidence tten notification to the tative and written notification or Resident #114's facility the hospital on 09/21/18 riginally admitted to the His diagnoses included Vascular Accident (Stroke), as on one side of the body), swallowing), Aphasia Urinary Tract Infection, the II (a condition causing ugar in the blood), Epilepsy (3), and Heart Failure (4). It is sessment was a 14-Day tent with an ARD of 10/09/18. View for mental status) 4 at 11, indicating moderate to the hospital on 09/21/18. It is do 11/14's record revealed he is to the hospital on 09/21/18. It is do 11/14's record revealed he is to the hospital on 09/21/18. It is do 11/14's record revealed he is to the hospital on 09/21/18. It is do 11/14's record revealed he is to the hospital on 09/21/18. It is time to take Resident to cher for evaluation and insible party) aware." There on of what, if anything was to the emergency room. It is the total control of written notice is sponsible representative or was notified of this facility	F 6.	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018	
	ROVIDER OR SUPPLIER	.ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	conducted with OS social worker. Whe ombudsman was not hospital, OSM # state notifying the ombud hospital. Only for room of the Administrator, member) #1 and AS were informed of the meeting on 10/25/1 was provided. 1. Sepsis is a serior your body has an oresponse to a bacter released into the black trigger widespread blood clots and leal poor blood flow, whorgans of nutrients one or more organs pressure drops and septic shock. This is the website: https://	It happens when verwhelming immune erial infection. The chemicals ood to fight the infection inflammation. This leads to key blood vessels. They cause ich deprives your body's and oxygen. In severe cases, a fail. In the worst cases, blood the heart weakens, leading to information was obtained from medlineplus.gov/sepsis.html	F 6				
	have strange sensa strangely. They ma or lose consciousne obtained from the v https://medlineplus.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495227	B. WING _			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	the most common ty is a disorder in the hean lead to an incre patients, it can also attack, or heart failu obtained from the whittps://medlineplus.g. 4. Heart failure is a can't pump enough needs. Heart failure heart has stopped of means that your heart has stopped of means that your heart he way it should. It of the heart. The we pumping ability caus up into the lungs, Thankles and legs - cashortness of breath. failure are coronary pressure and diabet obtained from the whittps://medlineplus.g. 5. Rigors are episod rises - often quite quishivering accompant ('the chills'). The few shivering may be quinformation was obtahttps://patient.info/h	peat. Atrial fibrillation (AF) is upe of arrhythmia. The cause heart's electrical system. AF ased risk of stroke. In many cause chest pain, heart re This information was ebsite: gov/atrialfibrillation.html condition in which the heart blood to meet the body's does not mean that your r is about to stop working. It art is not able to pump blood can affect one or both sides takening of the heart's ses: Blood and fluid to back the buildup of fluid in the feet, after disease, high blood es This information was ebsite: gov/heartfailure.html des in which your temperature sickly - whilst you have severe ied by a feeling of coldness er may be quite high and the sine dired from the website:	F	623			
	Resident #83's facili on 7/25/18. Resident #83 was a	ombudsman was notified of ty-initiated hospital transfer dmitted to the facility on itted on 7/27/18 with					

		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			10/	25/2018	
NAME OF PROVIDER OR SUF WESTPORT REHABILITA		NURSING CENTER	'	73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE CICHMOND, VA 23226			
PREFIX (EACH	DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
end stage repressure, framuscle weal MDS (Minim quarterly assisted as be 13 out of post for Mental State and T/25/18. The notified by the (temperature given then in increased to notified MD (Name of Right) 911 per required (evaluation) continue to responsible for the long-term on 10/25/18 conducted with long-term of the	that included and disease acture of he kness. Resum data se sessment wate) of 10/22 ing intact ir ssible 15 or tatus) examples and transport of the control	I but were not limited to e, heart failure, high blood or right lower leg, and ident #83's most recent et) assessment was a vith an ARD (assessment 2/18. Resident #83 was a cognitive function scoring in the BIMS (Brief Interview in. B's clinical record revealed efferred to the hospital on note was written: "Writer dent has a high temp essessed temp. RN (as needed) Tylenol (1) in the cotor) office and spoke to do nurse) (sic) send out of hospital) for eval. Insible party) aware. Will the present documents that it #83 at the time of the en notification to the inical record failed to otification was provided to	F	623				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			0/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 623	long term care on hospital, LPN # st the long-term care On 10/25/18 at 12 conducted with O social worker. Who ombudsman was hospital, OSM # s notifying the ombu hospital. Only for On 10/25/18 at 12 staff member) #1, #2, the administrator, ASI administrator, ASI administrator, ASI nursing) and ASI all made aware of No further informational made aware of the Treats minor ache fever. This inform National Institutes https://www.ncbi.r.T0008785/?report 8. The facility staff the long-term care Resident #108's fon 10/8/18. Resident #108 was 9/28/18 and readress.	en asked if nursing notified the abudsman for a transfer to the ated that nursing did not notify e ombudsman. 2:13 p.m., an interview was SM (other staff member) #3, the en asked if the long-term care notified of acute transfers to the stated, "No, we are not currently adsman for transfers to the routine discharges." 2:47 p.m., ASM (administrative the senior administrator, ASM stor, ASM #3, the assistant M #4, the other assistant M #5, the DON (Director of M #4, the medical director were the above concerns. ation was presented prior to exit. 325 mg (Acetaminophen): as and pains and also reduces nation was obtained from The sof Health. hlm.nih.gov/pubmedhealth/PMH	F6	523			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		1	0/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	heart failure, chronic disease, anemia, modisease, anemia, modisease, anemia, modisease, anemia, modisease, anemia, modisease mellitus. Recomprehensive MDS assessment had not Resident #108 was notes as being alert place, time). Review of Resident revealed that she had initiated transfer on nursing note was do Change in condition (saturation) noted at oxygen via nasal caminute). NP (nurse president placed on non-rebreather mas 85-92Interventions hospital. Emergency The next note dated (emergency medical transport Resident to detailed report giver necessary document (history and physical progress notes, medical plan." Facility staff were all were sent with Resident Resident were sent with Resident were sent with Resident plan."	espiratory failure with hypoxia, cobstructive pulmonary uscle weakness, and type two esident #108's 6 (minimum data set) 7 yet been completed. 8 documented in the nursing and oriented x3 (person, 8 #108's nursing notes 8 and an acute care facility 10/8/18. The following 9 cumented at 11:16 a.m.: 10 noted related to 02 sats 15 percent on continuous 15 percent on continuous 16 nulla at 4 lpm (liters per 17 percentioner) made aware. 18 sets ranging from 19 se Emergency transfer to 19 medical transportation. 10/8/18 at 11:30 a.m.: "EMS 18 services) arrived to facility to 19 percention of (Name of hospital) hospital, in to EMS per NP and all the sent with EMS, H&P 19 ped hold, transfer form, dication list, SBAR (situation, ment, recommendation), only tests)/x rays, and care 10 percent documents that dent #83 at the time of the 19 percentication to	F 623	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		1	0/25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 623	Continued From page	e 68	F 62	23			
	evidence that written the long-term care or On 10/25/18 at 10:54	a.m., an interview was					
	When asked who wa was sent out to the h (responsible party) at made aware. When a long term care ombut	(licensed practical nurse) #5. s notified when a resident ospital, LPN # stated that RP and the medical doctor were asked if nursing notified the dsman for a transfer to the d that nursing did not notify abudsman.					
	conducted with OSM social worker. When ombudsman was not hospital, OSM # state	s p.m., an interview was (other staff member) #3, the asked if the long-term care ified of acute transfers to the ed, "No, we are not currently man for transfers to the tine discharges."					
	staff member) #1, the #2, the administrator, administrator, ASM # administrator, ASM #	p.m., ASM (administrative e senior administrator, ASM , ASM #3, the assistant 4, the other assistant 5, the DON (Director of 4, the medical director were e above concerns.					
	No further information	n was presented prior to exit.					
	the long-term care or	iled to provide evidence that nbudsman was notified of ity-initiated hospital transfer					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE COMF	SURVEY PLETED			
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER RT REHABILITATION AI	ND NURSING CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOREST AVE CHMOND, VA 23226		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Resident #133 was 9/24/18 and readmit diagnoses that inclu muscle weakness, phigh blood pressure repeated falls. Resi complete MDS asse in the nursing notes x3 (person, place, till Review of Resident revealed that she hat hospital on 9/25/18. documented: "New (Name of hospital) for (related to) increase respiratory rate, decisaturation). per (sic) (Name of NP). RP (noted at bedside." The next noted date documented the follor (emergency room) in Resident left building 630 pm (sic) The foll given/sent with their (situation, backgroup Physical), Physician notes, Bed (sic) Holenotice and copy of comparison of the seponsible party. Further review of the	admitted to the facility on ted on 9/28/18 with ded but were not limited to eneumonia, hypothyroidism, muscle weakness, and dent #133 did not have a ressment but was documented as being alert and oriented	F	623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		10	0/25/2018
	ROVIDER OR SUPPLIER	O NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	conducted with LPN (When asked who was was sent out to the hour (responsible party) are made aware. When a long term care ombut hospital, LPN # stated the long-term care on On 10/25/18 at 12:13 conducted with OSM social worker. When a ombudsman was notin hospital, OSM # state notifying the ombudshospital. Only for rout On 10/25/18 at 12:47 administrator, ASM # 50 conducted with CSM was not the spital.	a.m., an interview was licensed practical nurse) #5. Is notified when a resident pospital, LPN # stated that RP and the medical doctor were sked if nursing notified the disman for a transfer to the disman for a transfer to the disman. p.m., an interview was (other staff member) #3, the asked if the long-term care fied of acute transfers to the di, "No, we are not currently man for transfers to the ine discharges." p.m., ASM #1, the senior 2, the administrator, ASM inistrator, ASM #4, the other	F 6	23		
F 625 SS=E	director were all made concerns. No further information Notice of Bed Hold Po	n was presented prior to exit. Dlicy Before/Upon Trnsfr	F 6	25		12/1/18
	§483.15(d)(1) Notice nursing facility transfethe resident goes on	bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ID NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES II (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE REGULATORY OR LSC IDENTIFYING INFORMATION) TA		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 625	Continued From pag	e 71	F 6	25		
	specifies- (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed plan, under § 447.40 (iii) The nursing facility bed-hold periods, where paragraph (e)(1) of the resident to return; and (iv) The information of this section. §483.15(d)(2) Bed-held the time of transfer of the hold periods with the time of transfer of the section. §483.15(d)(2) Bed-held the time of transfer of the time of trans	specified in paragraph (e)(1) old notice upon transfer. At		Corrective Action Resident # 51 returned form ton 10/17/18. Providing the resident # 51.		
	46 residents in the s #51, #52, #158, #11 1. The facility staff fa hold policy was prov	illed to evidence a written bed ided to the resident and/or ve for a facility initiated		resident representative with a hold policy upon transfer is no applicable Resident # 52 returned from ton 9/20/18. Providing the resident representative with a	o longer he hospital dent and/or written bed	
		niled to provide Resident # 52 resentative written notification		hold policy upon transfer is no applicable	olonger	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		URVEY ETED
		495227	B. WING _		10/2	5/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
WESTPOR	RT REHABILITATION A	AND NURSING CENTER		7300 FOREST AVE		
	. Ken beling			RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	Continued From pa	nge 72	F 6	25		
	transferred to the h	cy when the resident was ospital on 09/16/18.		Resident # 158 returned from on the same day that she was ER, 10/14/18. Providing the resident representative	s sent to the esident	
	158 or the resident notification of the b	failed to provide Resident # 's representative written ed hold policy when the erred to the hospital on		and/or resident representative written bed hold policy upon t longer applicable		
	bed hold notification	failed to evidence that written n was provided to the resident a hospital transfer pf Resident		Resident # 117 returned from on 9/18/18. Providing the res resident representative with a hold policy upon transfer is no applicable	ident and/or written bed	
	5. The facility staff bed hold notification representative for a	failed to evidence that written n was provided to the resident a facility initiated hospital t #114 on 09/21/18.		Resident # 114 returned from on 9/25/18. Providing the resiresident representative with a hold policy upon transfer is no applicable	dent and/or written bed	
	hold policy was pro	failed to evidence a written bed wided to the resident and/or a facility initiated		Licensed Nurses were re-edu 10/29/18 on the requirement written notification of the Bed at the time of transfer to the hold. 2. Other Potential Residents	to provide Hold policy	
	12/12/97, with rece with diagnoses that to: cerebral palsy [I control due to perm damage occurring I (1)], urinary retention disorder characterization difficulty in breathin mucus production, bronchi. (2)], and re	admitted to the facility on intreadmission on 8/10/18, included but were not limited oss or deficiency of muscle nanent, nonprogressive brain before or at the time of birth. In asthma [respiratory zed by recurrent episodes of ag, wheezing, cough, and thick caused by inflammation of the espiratory failure with hypoxia at of available oxygen in the		Residents who have been tra the hospital have the potential affected. A 50% audit was completed of for all residents that have been hospital over the past 3 mont resident that did not have do of written notice of bed hold p resident/resident representati clinical record at the time of the licensed nurse responsible had counselled.	on 10/29/18 en sent to the ths. For any cumentation solicy to the ve in the ransfer, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018	
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			000 FOREST AVE		
				RI	ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	e 73	F 6	525			
	assessment, a quarter assessment reference resident as being in a state/no discernable. The nurse's note date documented in part, related to noted audil (shortness of breath) elevated temp (tempor condition started on 0 started, it has gotten	ed, 8/6/18 at 11:45 (a.m.) 'Change in condition noted ble wheezing, gurgling, SOB, elevated respirations, erature). This change in 08/06/2018. Since this worse INTERVENTIONS:			3. Systemic Changes Documentation will be reviewed weekly 3 months for all residents' that are transferred to the hospital to validate the written notice of the bed hold policy was provided to the resident/resident representative at the time of transfer areas of non-compliance will be immediately corrected and the responsible staff will be counselled.	nat Is	
	started, it has gotten worse INTERVENTIONS: Emergency transfer to hospital. No additional recommendations made Emergency contact person was notified on 08/06/2018 at 12:00 AM (sic)." The physician order dated 8/6/18 documented, "Send to ER (emergency Room) for eval (evaluation)." Further review of the clinical record				4.MonitoringThe results of all audits will be forward to the QAPI Committee for review and recommendations.5.Date of compliance	ed	
	the time of transfer of	provided a bed hold policy at			12/1/18		
	practical nurse) # 6 or regarding what is ser resident is transferred following go with the Capabilities List (a lishome can provide) To Copy of Medication Lonew medications, No Discharge form, and the care plan was southem (residents). Wh	n 10/25/18 at 10:28 a.m., In to the hospital when a Id. LPN #6 stated the resident: Nursing Home It of services the nursing ransfer form, Face sheet, ist - updated with changes of			4. The results of all audits will be forwarded to the QAPI Committee for review and recommendations.5.Date of compliance12/1/18		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _		1	0/25/2018		
	ROVIDER OR SUPPLIER	AND NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIF 7300 FOREST AVE RICHMOND, VA 23226	· · · · · · · · · · · · · · · · · · ·			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 625	We also send the The facility policy documented in parepresentative will following informat policy." The "QA (quality a received on 10/25 (administrator. The Action Plan didentified in root of Through chart revidid not have compaperwork that was when being transfevaluation. Action be Re-educated of documentation of resident to the hopos (physician of transfer form with policy and care pleased administrator), As administrator), As administrator), As administrator), As and ASM #6 (the aware of the above p.m. No further in completion of the (1) Barron's Dictional policy and care pleased as the property of the aware of the above p.m. No further in completion of the (1) Barron's Dictional policy and care pleased as the property of the above p.m. No further in completion of the co	would but not sure if it's needed. bed hold policy." "Transfer or Discharge Notice" art, "3. The resident and/or I be notified in writing of the ion: e. The facility bed-hold assurance) Action Plan was 5/18 at 11:10 a.m. from ASM aff member) # 3, the assistant e Action Plan was dated 9/1/18. ocumented in part, "Factors ause analysis of this issue riew it was noted that residents' polete documentation of all as sent with or given to resident ferred to the hospital for is planned: Licensed Nurses will on the importance of accurate all documents that are sent with spital including but not limited to rider summary), Capabilities List, reason for transfer, bed hold an." In the importance of nursing) medical director) were made we concern on 10/25/18 at 12:41 formation was provided by survey. In any of Medical Terms for the der, 5th edition, Rothenberg and	F	525				

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			0/25/2018		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	10/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 625	Non-Medical Readed Chapman, page 44' 2. The facility staff for the resident's report the bed hold policy transferred to the hold policy transferred to the hold policy transferred to the hold Resident # 52 was a 05/23/18 with diagram of limited to: dysphosometric diagram of limited to: dysphosometr	ary of Medical Terms for the er, 5th edition, Rothenberg and 7. ailed to provide Resident # 52 presentative written notification by when the resident was pospital on 09/16/18. admitted to the facility on coses that included but were nagia (1), hypertension (2), 3) and hemiplegia (4). Streeent MDS (minimum data present with an ARD force date) of 09/06/18, coded foring a 7 (seven) on the brief status (BIMS) of a score of 0 and severely impaired of 3 daily decisions. Pass Notes" for Resident # 52 for the document at the status of the status in the status of	F 62					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _		10/:	25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 625	administrator, ASM # ASM # 5 director of n medical director were findings. No further information References: (1) A swallowing diso obtained from the we https://www.nlm.nih.g sorders.html. (2) High blood pressuobtained from the we https://www.nlm.nih.g essure.html. (3) A stroke. When b brain stops. A stroke attack." If blood flow few seconds, the brain oxygen. Brain cells cadamage. This information website: https://medlineplus.go. (4) Also called: Heming Quadriplegia. Paraly function in part of you something goes wrom pass between your broan be complete or p both sides of your boone area, or it can be	4 assistant administrator, ursing and ASM # 6, a made aware of the a was provided prior to exit. In was provided prior to exi	F 6	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CI 7300 FOREST AVE RICHMOND, VA 23	, ,		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH C	VIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 625	158 or the resider notification of the resident was trans 10/14/18. Resident # 158 was 06/26/17 with diagnot limited to: head disorder (2), anen pulmonary diseas recent MDS (minit assessment with a date) of 10/11/18, scoring a 13 on the status (BIMS) of a cognitively intact for the nurse's "Prog documented, "10/condition noted reof burning at 7:30 cool clammy, slow hospital."	age 77 If failed to provide Resident # It's representative written bed hold policy when the Isferred to the hospital on It is admitted to the facility on It is admitted to the	F	525	DEFICIENCY)		
	member) # 3, ass asked to provide of 158 or that Reside received written n when the resident on 10/14/18, ASM	stant administrator. When documentation that Resident # ent # 158's representative otification of the bed hold policy was transferred to the hospital # 3 stated, "We don't have g the resident's transfer."					
	(administrative sta	proximately 12:45 p.m., ASM iff member) # 2, the ASM # 2, assistant V # 4 assistant administrator,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING	 	10/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 625	Continued From pa	nge 78	F 62	55		
		f nursing and ASM # 6, ere made aware of the				
	No further informati	ion was provided prior to exit.				
	to pump oxygen-rice efficiently. This cau throughout the bod obtained from the vhttps://medlineplus (2) Depression may blue, unhappy, mis Most of us feel this short periods. Clinidisorder in which feor frustration interfeor more. This inforwebsite: https://medlineplus (3) Low iron. This in the website: https://www.nlm.nih (4) Disease that macan lead to shortnewas obtained from https://www.nlm.nih.4. The facility staff bed hold notification.	gov/ency/article/000158.htm. y be described as feeling sad, erable, or down in the dumps. way at one time or another for ical depression is a mood eelings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. Information was obtained from an.gov/medlineplus/anemia.html				
	Resident #117 was	admitted to the facility on				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(×	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		_	10/25/2018		
	ROVIDER OR SUPPLIER	ND NURSING CENTER	1	STREET ADDRESS, CITY, STA 7300 FOREST AVE RICHMOND, VA 23226	ATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 625	Vascular Accident (in Dysphagia (difficulty speaking)) Disorder. Her most (MDS) Assessment Assessment with an (ARD) of 10/04/18. Status (BIMS) score indicating minor important in the status (BIMS) score indicating	osses included Cerebral Stroke), Muscle Weakness, y swallowing), Aphasia , and Major Depressive recent Minimum Data Set was a Significant Change n Assessment Reference Date The Brief Interview for Mental ed Resident #117 at 13,	F	525				
	The Administrator, member) #1 and Di were informed of th Meeting on 10/25/1 provide this surveyor.	ASM (administrative staff rector of Nursing, ASM #2 e findings at the End of Day 8. When asked if they could or with documentation g proof of the bed hold policy tal discharges, the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10	/25/2018
	ROVIDER OR SUPPLIER	AND NURSING CENTER		7300 I	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE IMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 625	bed hold notification representative for transfer of Resident Resi	failed to evidence that written on was provided to the resident a facility initiated hospital at #114 on 09/21/18. Is originally admitted to the condition of diagnoses included Sepsis ular Accident (Stroke), the session one side of the body), the session of sugar in the blood), Epilepsy on (3), and Heart Failure (4). IDS (minimum data set) of 14-Day Admission on ARD (assessment reference of the BIMS scored Resident in many moderate impairment. The sent #114's record revealed he ded to the hospital on 09/21/18. The sent do 10/21/18 at 10:00p.m. In this time to take resident to retcher for evaluation and consible party) aware." There are attention of what, if anything, was sent to the emergency room. The conducted with LPN (licensed on 10/25/18 at 10:28 a.m. of keep copies of the Notice of the properties of the Notice of t	F	525			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	Continued From pag	ge 81	F 6	25		
	documentation to ever policy was provided Responsible Party.					
	member) #1 and Dir were informed of the Meeting on 10/25/18 provide this surveyo	SM (administrative staff ector of Nursing, ASM #2 findings at the End of Day B. When asked if they could r with documentation				
	being sent on hospit the Administrator, A					
	your body has an overesponse to a bacter released into the blottrigger widespread in blood clots and leak poor blood flow, whi	s illness. It happens when berwhelming immune rial infection. The chemicals od to fight the infection inflammation. This leads to by blood vessels. They cause the deprives your body's				
	one or more organs pressure drops and	and oxygen. In severe cases, fail. In the worst cases, blood the heart weakens, leading to medlineplus.gov/sepsis.html				
	to have recurring se when clusters of ner brain send out the w have strange sensal					
	rhythm of the heartb	a problem with the speed or eat. Atrial fibrillation (AF) is pe of arrhythmia. The cause eart's electrical system. AF				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/2	25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	Ē	(X5) COMPLETION DATE
F 625	patients, it can also cattack, or heart failure https://medlineplus.go 4. Heart failure is a cocan't pump enough blineeds. Heart failure dheart has stopped or means that your heart the way it should. It cof the heart. The wear pumping ability cause up into the lungs, The ankles and legs - callushortness of breath. Of failure are coronary apressure and diabete https://medlineplus.go 5. Rigors are episode rises - often quite quite shivering accompanie ('the chills'). The feve shivering may be quite https://patient.info/heart.	sed risk of stroke. In many ause chest pain, heart by a chest pain, he chest pain, he chest pain, he chest pain by a c		625			12/1/18
33-0	§483.21(b) Comprehe §483.21(b)(1) The fac- implement a compreh care plan for each res resident rights set for §483.10(c)(3), that ind objectives and timefra medical, nursing, and	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			0/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		0.20.20.10	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	describe the follow (i) The services the or maintain the rephysical, mental, required under §4 (ii) Any services the under §483.24, §4 provided due to the under §483.10, in treatment under §4 (iii) Any specialized rehabilitative serve provide as a result recommendations findings of the PA rationale in the resident's repressed (A) The resident's desired outcomes (B) The resident's future discharged whether the resident community was also allocal contact agent entities, for this proposed contact agent entities and the proposed contact agent entities are contact agent entities.	comprehensive care plan must wing - lat are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and hat would otherwise be required 483.25 or §483.40 but are not he resident's exercise of rights cluding the right to refuse 483.10(c)(6). In deservices or specialized ices the nursing facility will be for the facility disagrees with the SARR, it must indicate its sident's medical record. With the resident and the entative(s)- goals for admission and facilities must document ent's desire to return to the essessed and any referrals to incies and/or other appropriate arross. In the comprehensive care are, in accordance with the forth in paragraph (c) of this entity staff interview, facility and clinical record review, it mat the facility staff failed to imprehensive care plan for three the survey sample, Resident #	F6	1. Corrective Action Nursing and Activity Staff ware-educated on 10/29/18 on importance of knowing and residents care plan. The car	the following the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10	/25/2018	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
				73	300 FOREST AVE			
WESTPOF	RT REHABILITATION AN	D NURSING CENTER		R	ICHMOND, VA 23226			
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	e 84	F 6	656				
	. •				Residents # 42, # 73 and # 46 specific	allv		
	1. The facility staff fa	iled to implement the			have also been reviewed with the staff	-		
	-	plan for Resident # 42.				•		
					2.Other Potential Residents			
	2. The facility staff fa	iled to implement the						
	activities care plan fo	•			Residents that have a care plan that			
	·				addresses communication problems,			
	3. The facility staff fai	led to implement the care			oxygen therapy and an activities care	olan		
	plan for the administration of oxygen for Resident				that they enjoy watching TV have the			
	#73.				potential to be affected. An audit was			
					completed on 11/9/18 for a random			
	The findings include:				sample of these residents to validate the	nat		
					staff are familiar with and following the			
	The facility staff fa				residents plan of care. Any areas of			
	communication care	plan for Resident # 42.			non-compliance has been corrected ar	nd		
	D				the appropriate staff have been			
		dmitted to the facility on			counselled.			
		ses that included but were			2. Customia Changes			
		oss, both eyes, hearing loss, hagia (2), hemiplegia (3)			3. Systemic Changes			
	and cerebrovascular				A 25% audit of care plans/observations	for		
	and cerebiovascular	uisease (4).			residents that have a care plan that	5 101		
	Resident # 42's most	recent MDS (minimum data			addresses communication problems,			
	set), a quarterly asse	•			oxygen therapy and an activities care	olan		
		ce date) of 08/23/18, coded			that they enjoy watching TV will be			
		ring a 5 (five) on the brief			completed weekly x 3 months to valida	te		
	interview for mental s	tatus (BIMS) of a score of 0			that staff are familiar with and following			
	- 15, 5 (five) - being s				the residents plan of care. Any areas of	f		
		daily decisions. Resident #			non-compliance will be immediately			
		uiring extensive assistance			corrected and the appropriate staff will	be		
		or locomotion, eating, toilet			counselled.			
		and being totally dependent						
		or dressing, personal			4. Monitoring			
	hygiene and bathing.							
		coded Resident # 42 as			The results of all audits will be forward	ed		
		vo) - Moderate difficulty,			to the QAPI Committee for review and			
	,) - Severely impaired - no			recommendations.			
	, , ,	ht, colors or shapes, eyes			E Data of compliance			
	do not appear to follo	w objects.			5.Date of compliance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			0/25/2018	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From pag	e 85	F 65	6			
	resident # 42's room nursing assistant) # room. CNA # 3 was Resident # 42 on the 3 set up the Residen over-the-bed table, s of Resident # 42 and from the resident's ri observed speaking to right side throughout was sitting up in bed second staff membe # 42's room during the side of the bed and se 6 was observed repe- statement/questions	a.m., an observation of revealed CNA (certified 3 entered Resident # 42's observed speaking to e resident's right side. CNA # at # 42's breakfast tray on the sat in a chair on the right side I assisted her with breakfast ght side. CNA # 3 was on Resident # 42 from her at the meal. Resident # 42. During the observation, a rr CNA # 6 entered Resident he meal, stood at the right spoke to the resident. CNA # seating her to Resident # 42 and raising resident heard her and		12/1/18			
	observation of Resid	ent # 42's room revealed a net head of the bed that of Resident) is completely right ear."					
	Resident # 42 reveal headphones on. CN closed the door to pr Resident # 42. At 6: conducted with CNA providing care. Whe 42's hearing CNA # 4 hearing but she hear her head set and tell Sometimes I have to	p.m., an observation of led she was lying in bed with IA # 4 entered the room and ovide personal care to 00 p.m., an interview was # 4 when she finished en asked about Resident # 4 stated, "She's hard of s you pretty good. I take off her what I'm going to do. speak up or I get close to ed which ear she speaks into,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	ID NURSING CENTER	·	7	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From pag CNA # 4 stated, "He On 10/25/18 at 8:55 right side of the bed with breakfast. The speaking to Residen The POS (physician' 10/01/2018 thru 10/3 documented, "Diagn The comprehensive with a target date of "Focus: Difficulty cor hearing loss/deafnes directly into left ear." it documented, "Rem slower/louder into lef 01/23/2018." Interview 10/25/18 0 conducted with CNA Resident # 42 had at # 3 stated, "(Resider	e 86 right side." a.m., a staff member on the was assisting Resident # 42 staff member was observed t # 42 on her right side. s order sheet) dated 1/2018 for Resident # 42 osis: Deaf in right ear." care plan for Resident # 42 11/21/2018 documented, namunicating related to str (right) ear. Need to talk Under "Interventions/Tasks" hind staff to speak it ear. Revision on		656	DEFICIENCY)	AIE	
	speaking with her, C working with her exp before I do it. We ta talk into the left ear." of the observation or CNA # 3 stated, "We hear and there isn't e of her bed for a chair a plan for Resident # approach to speak to not aware of any pla When asked if she h	approaches to be taken when NA # 3 stated, "When we are lain what I'm going to do lk loud so she can hear and After CNA #3 was informed in 10/24/18 during breakfast, talk loud enough so she can enough room on the left side it." When asked if there was it 42 that outlined an other, CNA # 3 stated, "I'm in as to how to speak to her." and access to Resident # 42's stated, "We have access to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			TE SURVEY MPLETED
		495227	B. WING _			0/25/2018
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 656	how to take care of communication careviewed on the knasked to read the #3 stated, "To speaked if she was find plan for speaking stated, "No not condescribe the purpostated, "To know hensure you give the asked if interventing plan should be followed by the stated, "It was to conducted with LF9, unit manager." Sensory deficits R stated, "Her senson hard of hearing." Observation of the staff speaking to F9 stated, "I mean when asked if the use when community stated, "They side." After review communication can they were following for Resident #42. The facility's policy Assessments and documented, "Decoperson-centered pand implementing and implementing the state of the person-centered pand implementing the person-centere	the electronic kiosk that tells us of the resident." The are plan for Resident # 42 was iosk with CNA # 3. When communication care plan, CNA eak into the left ear." When following Resident # 42's care into her left ear, CNA # 3 ampletely." When asked to ose of the care plan, CNA # 3 now to care for the resident and them the proper care." When consider downward on the care flowed, CNA # 3 stated, "Yes." 43 a.m., an interview was PN (licensed practical nurse) # When asked what type of the esident # 42 had, LPN # 9 tory deficits are that she is blind when informed of the sign in the room and of the Resident # 42's right ear, LPN # partially deaf, deaf in right ear." For was a strategy for staff to incating with the resident, LPN should be speaking into her left wing Resident # 42's are plan, LPN # 9 was asked if g the communication care plan LPN # 9 stated, "No." The comprehensive the Care Delivery Process" cision making leading to a plan of care includes: Selecting	F	356		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING	· · · · · · · · · · · · · · · · · · ·		10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 656	F 656 Continued From page 88 (administrative staff member) # 2, the		F 65	66		
	administrator and A administrator, ASM ASM # 5 director of	•				
	No further information	on was provided prior to exit.				
	to pump oxygen-ricl efficiently. This caus throughout the body obtained from the w	nich the heart is no longer able in blood to the rest of the body sees symptoms to occur. This information was rebsite: gov/ency/article/000158.htm.				
	obtained from the w	order. This information was rebsite: .gov/medlineplus/swallowingdi				
	Quadriplegia. Para function in part of yo something goes wro pass between your can be complete or both sides of your b one area, or it can be information was obt https://medlineplus.	. ,				
	brain stops. A stroke attack." If blood flow few seconds, the broxygen. Brain cells	blood flow to a part of the e is sometimes called a "brain w is cut off for longer than a ain cannot get nutrients and can die, causing lasting nation was obtained from the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		1	0/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	2. The facility sta activities care plant Resident # 46 wa 10/31/16 with diagnot limited to: den anemia (3) and spreading Resident # 46's material set interview for mention of the factorial set int	s.gov/ency/article/000726.htm . Iff failed to implement the in for Resident # 46. Is admitted to the facility on gnoses that included but were nentia (1), dysphagia (2), binal stenosis (4). Inost recent MDS (minimum data issessment with an ARD rence date) of 08/30/18, coded scoring a 5 (five) on the brief tal status (BIMS) of a score of 0 ing severely impaired of ing daily decisions. Resident # requiring extensive assistance per for locomotion, dressing, I mobility and being totally staff member for transfers, anygiene and bathing. Section F Customary Routine and Resident # 42 as 1 (one) - "Very 'D. how important is it to you to	F 6	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		OATE SURVEY OMPLETED
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	•	
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F 656	listening to, CNA (ce stated, "The T.V." of for Resident # 46's mounted on the wall revealed that there is television was off. We Resident # 46's room # 4 pointed to Resid was mounted on the room. CNA # 4 state her roommate's (resident # 46's television that the room television that the condition of the room television revealed is television revealed to coming from the television that the room television revealed to coming from the television that the room television revealed to the room television revealed to coming from the television that the room television revealed to the room that the room television revealed to the room that the room	at # 46's roommate was entified nursing assistant) # 4 abservation of the television commate, which was at the foot of the bed, was no picture and the When asked what television mate was listening to, CNA ent # 46's television, which wall on the A-side of the ed, "She's listening to that ed, "(Resident # 42) listens to ident # 46) T.V." When 46's roommate listens to vision while Resident # 46 evision without any sound, infirmed the arrangement didn't have a response. a.m., observation of led she was lying in bed oning the television on her side vation of her wall-mounted to was on and tuned into a Further observation of the that there was no sound evision. Observation of the	F	656		
	revealed she was si closed and the head her ears and being a with breakfast. Whe 46's roommate was "The T.V." Observa Resident # 46's room on the wall at the for there was no picture.	dent # 46's roommate tting up in bed with her eyes phones on her head and over assisted by a staff member en asked what Resident # listening to, CNA # 3 stated, tion of the television for mate, which was mounted of the bed, revealed that and the television was off. elevision Resident # 46's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		,	10/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	Resident # 46's televithe wall on the A-sid "She's listening to the "(Resident # 42) listed (Resident # 46) T.V. 46's roommate lister television while Resident elevision without and confirmed the arrange thought that this arrange didn't have a responsion on 10/25/18 at 9:14 Resident # 46 reveal her television. Observealed it was on a coming from it. What television Resident # asked if she wanted Resident # 46 stated Resident # 46 stated The "Activity Evalua 10/17/2016 docume Viewing/Radio" Currous: Enjoys active pets/animals, group appropriate weather games and socials." documented, "Will pleisure activities of civisitors." On 10/25/18 at 9:43 conducted with LPN	ning to, CNA # 3 pointed to vision, which was mounted on e of the room and stated, at one." CNA # 3 stated, ens to her roommate's "When asked if Resident # as to Resident # 46's dent # 46 looks at her own y sound CNA # 3 verbally gement. When asked if she angement was okay, CNA # 3 se. a.m., an observation of led she was in bed looking at ervation of the television and there was no sound en asked if she could hear the # 46 stated, "No." When to hear her television d, "Yes but not loud." tion" for Resident # 46 dated anted, "C. 11. TV Program ent interest." care plan with a revision date esident # 46 documented, ities such as music, activities, outdoors in , religious/spiritual, exercise,	F 65				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		10/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICS)	D BE COMPLÉTION
F 656	listen to her television select preferred telev was asked to review plan. LPN # 9 was a the activity care plan stated, "No." On 10/25/18 at appro (administrative staff radministrator and AS administrator, ASM # ASM # 5 director of medical director were findings. No further information References: (1) A loss of brain fur diseases. It affects m judgment, and behave obtained from the we https://medlineplus.gu (2) A swallowing diso obtained from the we https://www.nlm.nih.gusorders.html. (3) Low iron. This inforthe website: https://www.nlm.nih.gusorders.html. (4) A narrowing of the pressure on the spins openings (called neurons asked to review plant and pressure on the spins openings (called neurons asked to review plant and pressure on the spins openings (called neurons asked to review plant approximation plant asked to review plant approximation plant approximation plant asked to review plant approximation plan	dent # 46 not being able to n or being given the choice to ision programming. LPN # 9 Resident # 46's activity care sked if staff was following for Resident # 46. LPN # 9 eximately 12:45 p.m., ASM member) # 2, the M # 2, assistant is 4 assistant administrator, iursing and ASM # 6, is made aware of the in was provided prior to exit. action that occurs with certain itemory, thinking, language, ior. This information was bsite: iov/ency/article/000739.htm. arder. This information was	F 656		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		1	0/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, 2 7300 FOREST AVE RICHMOND, VA 23226			
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F 656	3. The facility staff plan for the admini #73. Resident #73 was 12/12/97, with receive with diagnoses that to: cerebral palsy [control due to perrodamage occurring (1)], urinary retention disorder character difficulty in breathin mucus production, bronchi. (2)], and reginadequate amound blood. (3)]. The most recent Massessment, a quassessment refere resident as being i state/no-discernabing resident was code upon one or more activities of daily literatments, Proceive resident was code resident in the facility of the comprehensive revised on 9/24/18 for respiratory impasthma." The "Interior the comprehensive respiratory impasthma."	the website: s.gov/ency/article/000441.htm. failed to implement the care istration of oxygen to Resident admitted to the facility on ent readmission on 8/10/18, at included but were not limited loss or deficiency of muscle manent, nonprogressive brain before or at the time of birth. on, asthma [respiratory ized by recurrent episodes of ang, wheezing, cough, and thick caused by inflammation of the respiratory failure with hypoxia and of available oxygen in the IDS (minimum data set) arterly assessment, with an ance date of 9/13/18, coded the na persistent vegetative as being totally dependent staff members for all of his ving. In Section O - Special dures and Programs, the das using oxygen while a	F	656			

	IDENTIFICATION NUMBER:			` '	(X3) DATE SURVEY COMPLETED	
	495227	B. WING		10/	25/2018	
	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,	20/20 10	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
The physician order of (physician order sum physician on 10/18/18 (oxygen) @ (at) 2 LP remove prn (as need of Resident # 73 on 11:00 p.m. The resider oxygen on via a nasa prongs that insert into oxygen], connected to The oxygen concentr of the ball resting on minute and the top of line for 2.5 liters per robserved a second to the oxygen was set at the oxygen was in us oxygen concentrator the ball resting on the and the top of the ball 2.5 liters per minute. This observation. Observation was mad (licensed practical nup.m. LPN #6 verified liters per minute. Who flow meter of the oxygen was the concentrator the ball resting on the and the top of the ball 2.5 liters per minute. The October 2018 TA	on the October POS mary) and signed by the 3, documented, "O2 M (liters per minute) - may ed)." Observation was made 0/23/18 at approximately in twas in the bed with the il cannula [a tubing with two of the nose to deliver the of an oxygen concentrator, ator was set with the bottom the line for 2 liters per if the ball was sitting at the minute. The resident was me on 10/23/18 at 2:52 p.m. It the same rate. Ide on 10/24/18 at 8:28 a.m. Is evia the nasal cannula, the was set with the bottom of the line for 2 liters per minute, I was sitting at the line for Another surveyor verified Ide of Resident # 73 with LPN rese) #6 on 10/24/18 at 2:40 the rate was not set at 2 ten asked how to read the gen concentrator, LPN #6 ten prescribed rate should be the ball. When asked if the was set at the correct rate room, LPN #6 stated, "No, ten the lines."	F 65				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page The physician order of (physician order sum physician on 10/18/18 (oxygen) @ (at) 2 LP remove prn (as neede of Resident # 73 on 1 1:00 p.m. The resider oxygen on via a nasa prongs that insert into oxygen], connected to The oxygen concentr of the ball resting on minute and the top of line for 2.5 liters per r observed a second til the oxygen was set a Observation was mad The oxygen was in us oxygen concentrator the ball resting on the and the top of the bal 2.5 liters per minute. this observation. Observation was mad (licensed practical nu p.m. LPN #6 verified liters per minute. Who flow meter of the oxyg stated, the line for the through the center of Resident #73's oxyge when we entered the Ma'am. It was between The October 2018 TA record) documented to	A95227 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 94 The physician order on the October POS (physician order summary) and signed by the physician order summary) and signed by the physician on 10/18/18, documented, "O2 (oxygen) @ (at) 2 LPM (liters per minute) - may remove prn (as needed)." Observation was made of Resident # 73 on 10/23/18 at approximately 1:00 p.m. The resident was in the bed with the oxygen on via a nasal cannula [a tubing with two prongs that insert into the nose to deliver the oxygen], connected to an oxygen concentrator. The oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute and the top of the ball was sitting at the line for 2.5 liters per minute. The resident was observed a second time on 10/23/18 at 2:52 p.m. the oxygen was in use via the nasal cannula, the oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute, and the top of the ball was sitting at the line for 2.5 liters per minute, and the top of the ball was sitting at the line for 2.5 liters per minute. Another surveyor verified	ROVIDER OR SUPPLIER RET REHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 94 The physician order on the October POS (physician order summary) and signed by the physician or 10/18/18, documented, "O2 (oxygen) @ (at) 2 LPM (liters per minute) - may remove prn (as needed)." Observation was made of Resident # 73 on 10/23/18 at approximately 1:00 p.m. The resident was in the bed with the oxygen on via a nasal cannula [a tubing with two prongs that insert into the nose to deliver the oxygen], connected to an oxygen concentrator. The oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute and the top of the ball was sitting at the line for 2.5 liters per minute. The resident was observed a second time on 10/23/18 at 8:28 a.m. The oxygen was set at the same rate. Observation was made on 10/24/18 at 8:28 a.m. The oxygen was in use via the nasal cannula, the oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute, and the top of the ball was sitting at the line for 2.5 liters per minute. Another surveyor verified this observation. Observation was made of Resident # 73 with LPN (licensed practical nurse) #6 on 10/24/18 at 2:40 p.m. LPN #6 verified the rate was not set at 2 liters per minute. When asked how to read the flow meter of the oxygen concentrator, LPN #6 stated, the line for the prescribed rate should be through the center of the ball. When asked if Resident #73's oxygen was set at the correct rate when we entered the room, LPN #6 stated, "No, Ma'am. It was between the lines." The October 2018 TAR (treatment administration record) documented the above order for oxygen.	ROVIDER OR SUPPLIER TO THE HABILITATION AND NURSING CENTER THE HABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL (FEGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 94 The physician order on the October POS (physician order or on the October POS (physician order summary) and signed by the physician on 10/18/18, documented, "O2 (oxygen) @ (at) 2 LPM (Illers per minute) - may remove pm (as needed)." Observation was made of Resident # 73 on 10/23/18 at approximately 1:00 p.m. The resident was in the bed with the oxygen on via a nasal cannula [a tubing with two prongs that insert into the nose to deliver the oxygen], connected to an oxygen concentrator. The oxygen was set at the same rate. Observation was made on 10/24/18 at 8:28 a.m. The oxygen was in use via the nasal cannula, the oxygen was set at the same rate. Observation was made of Resident # 73 with LPN (licensed practical nurse) #6 on 10/24/18 at 2:40 p.m. LPN #6 verified the rate was not set at 2 liters per minute. Another surveyor verified this observation. Observation was made of Resident # 73 with LPN (licensed practical nurse) #6 on 10/24/18 at 2:40 p.m. LPN #6 verified the rate was not set at 2 liters per minute. When asked how to read the flow meter of the oxygen concentrator, LPN #6 stated, the line for the perscribed rate should be through the center of the ball. When asked if RECHARDING, Was a set at the cornect rate when we entered the room, LPN #6 stated, "No, Ma'am. It was between the lines."	A BUILDING 100 495227 B. WING 110 5/700 FOREST AVE RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENC) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 94 The physician order on the October POS (physician or 01/8/18, documented, "O2 (oxygen) @ (at) 2 LPM (filters per minute) - may remove prin (as needed)." Observation was made of Resident # 73 on 10/23/18 at approximately 1:00 p.m. The resident was in the bed with the oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute. The resident was observed a second time on 10/23/18 at 2:52 p.m. the oxygen was set at the same rate. Observation was made on 10/24/18 at 8:28 a.m. The oxygen was in use vide the nasal cannula, the oxygen concentrator was set with the bottom of the ball resting on the line for 2 liters per minute, and the top of the ball was sitting at the line for 2.5 liters per minute. Another surveyor verified this observation was made of Resident # 73 with LPN (licensed practical nurse) #6 on 10/24/18 at 2:40 p.m. LPN #6 verified the rate was not set at 2 liters per minute. When asked how to read the flow meter of the oxygen concentrator, LPN #6 stated, the line for the prescribed rate should be through the center of the ball. When asked if Resident # 73 soxygen was set at the correct take when we entered the room, LPN #6 stated, "No, Ma'am. It was between the lines." The October 2018 TAR (treatment administration record) documented the above order for oxygen.	

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		495227	B. WING		10/	/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	An interview was cor 10/25/18 at 10:16 a.r purpose of the care parake a plan of care expected for the paticare for the patient. I resident. When aske care plan, LPN #7 st. changes as we go." reviewed with LPN # was not set at the profollowing the care platechnically." ASM (administrative administrator), ASM administrator), ASM administrator), ASM administrator), ASM administrator), ASM and ASM #6 (the me aware of the above op.m. No further information (1) Barron's Dictional Non-Medical Reader Chapman, page 114. (2) Barron's Dictional Reader Chapman, page 51. (3) Barron's Dictional Reader Chapman, page 51.	Inducted with LPN #7 on m. When asked what the plan is, LPN #7 stated it is to for the patient, what is ent and certain things how to it is individualized to each diffit's important to follow the ated, "Yes. We make The care plan above was 7. When asked if the oxygen escribed rate, would that be an, LPN #7 stated, "Not staff member) #2 (the #3 (the assistant #4 (another assistant #5 (the director of nursing) dical director) were made concern on 10/25/18 at 12:41 in was provided prior to exit. Try of Medical Terms for the fig. 5th edition, Rothenberg and arry of Medical Terms for the fig. 5th edition, Rothenberg and arry of Medical Terms for the fig. 5th edition, Rothenberg and arry of Medical Terms for the fig. 5th edition, Rothenberg and arry of Medical Terms for the fig. 5th edition, Rothenberg and arry of Medical Terms for the fig. 5th edition, Rothenberg and	F 65	6		
F 657 SS=D	Chapman, page 286 Care Plan Timing and CFR(s): 483.21(b)(2)	d Revision	F 65	7		12/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 800 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From pag		F 6	657			
	§483.21(b) Compre §483.21(b)(2) A con be-	nensive Care Plans nprehensive care plan must					
	be- (i) Developed within the comprehensive (ii) Prepared by an i includes but is not li (A) The attending pl (B) A registered nurresident. (C) A nurse aide wit resident. (D) A member of foo (E) To the extent prathe resident and the An explanation mus medical record if the and their resident renot practicable for the resident's care plan. (F) Other appropriated disciplines as determor as requested by the includes the comprehensive services and their resident resident's care plan.	7 days after completion of assessment. Interdisciplinary team, that mited to nysician. It is with responsibility for the interpolation of the participation of resident's representative(s). It is included in a resident's representative is determined the development of the estaff or professionals in mined by the resident's needs the resident.					
	team after each ass comprehensive and assessments. This REQUIREMEN by: Based on observati record review, it was staff failed to review comprehensive care	T is not met as evidenced on, staff interview, and clinical s determined that the facility and/or revise the e plan for one of 46 residents			Corrective Action The care plan for resident #54 has bee revised to reflect the discontinuation of		
	Resident # 54's care	ed to review and/or revise			fall mat. 2. Other Potential Residents Residents that have had a discontinued	d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10	/25/2018
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				73	00 FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RI	CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	e 97	F 6	657			
	The findings include:				physicians order have the potential to laffected.	be	
	09/07/13 with diagnost not limited to: dyspha	dmitted to the facility on ses that included but were gia (1), hemiplegia (2), and hypertension (4).			Licensed Nurses responsible for revisithe care plan were re-educated on 10/12/18 regarding the process for revising the care plan.	ng	
	set), a quarterly asse (assessment reference Resident # 54 as sco- interview for mental standard resident in - 15, 15 - being cogni- decisions. Resident in extensive assistance locomotion, dressing	ce date) of 08/02/18, coded ring a 15 on the brief status (BIMS) of a score of 0 tively intact for making daily # 54 was coded as requiring of one staff member for and toilet use and being in the assistance of one staff			A audit of physicians orders for the pas 30 days was completed on 11/9/18 to validate that the care plan has been updated to reflect any discontinued order are no longer on the current plan of ca Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 3. Systemic Changes	ders re.	
	Resident # 54 revealed Observation of Reside evidence a fall mat. On 10/23/18 at 4:35 president # 54 revealed.	a.m., an observation of ed he was lying in his bed. ent # 54's room failed to o.m., an observation of ed he was in bed watching on of Resident # 54's room all mat.			A 25% audit of physicians orders will be completed weekly x 3 months to validathat the care plan has been updated to reflect that any discontinued orders are longer on the current plan of care. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4.Monitoring	ite o e no	
	Resident # 54 revealed paper. Observation of failed to evidence a factor of 10/24/18 at 1:28 parameters. Resident # 54 revealed to the factor of the factor	o.m., an observation of ed he was in bed watching on of Resident # 54's room			The results of all audits will be forward to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	ed	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		10/2	5/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 657	Continued From page	e 98	F 65	77		
	of 04/18/2018 for Rei "Focus: At risk for fal mobility, med (medic (cerebrovascular acc hypertension, depres use bowel and bladd Under "Interventions, against wall with fall i 12/23/2017." The "Physician's Tele 10/07/14 for Residen (discontinue) Fall Ma (secondary) to decre The POS (physician's 54 dated "10/01/2018 the physician on 10/1 failed to evidence ord maintain the bed clos On 10/25/18 at 8:52 a conducted with RN (r coordinator. RN #1 v observations of Resident Material Resident 10/31/2018, and Res When RN #1 was as been reviewed or rev orders for the discont 1 stated, "The care p the physician's order the process for review RN #1 stated, "It's de	ident) with left hemiparesis, sion with med (medication) er incontinent, vertigo." 'Tasks" it documented, "Bed mat to floor. Revision Date: ephone Order" dated tr # 54 documented, "D/C tr (and) D/C Personal alarm > ased fall risk." sorder sheet) for Resident # 8 thru 10/31/2018", signed by 8/18, for Resident # 54 ders for a fall mat or to be to the floor. a.m., an interview was registered nurse) # 1, MDS				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495227	B. WING	·	1	0/25/2018		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226				
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F 657	Continued From pag	ge 99	F 65	57				
	communicated from verbally through more care plan meetings.' On 10/25/18 at appr (administrative staff administrator and AS administrator, ASM a ASM # 5 director of	oximately 12:45 p.m., ASM member) # 2, the						
	No further information	on was provided prior to exit.						
	obtained from the we	order. This information was ebsite: gov/medlineplus/swallowingdi						
	Quadriplegia. Paraly function in part of you something goes wro pass between your becan be complete or poth sides of your become area, or it can be information was obtain https://medlineplus.cg. (3) A stroke. When brain stops. A stroke attack." If blood flow few seconds, the brain youngen. Brain cells of	ained from the website:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		10/25/2018		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
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F 658 SS=D	(4) High blood press obtained from the whttps://www.nlm.nih.essure.html. Services Provided M. CFR(s): 483.21(b)(3) Comp. The services provide as outlined by the comust- (i) Meet professiona This REQUIREMEN by: Based on observati document review an was determined the professional standar residents in the surv. The facility staff faile orders for insulin (1) #74. The findings include Resident #74 was a 7/23/15 with diagnost limited to: Huntingto	gov/ency/article/000726.htm . gure. This information was ebsite: gov/medlineplus/highbloodpr fleet Professional Standards)(i) prehensive Care Plans ed or arranged by the facility, omprehensive care plan, I standards of quality. T is not met as evidenced on, staff interview, facility d clinical record review, it facility staff failed to follow do of practice for one of 46 ey sample, Resident #74. Ed to clarify the physician administration for Resident : dmitted to the facility on ses that included but were not n's disease (2), Type 2	F 658	1. Corrective Action The order for insulin administration for Resident # 74 has been clarified. 2.Other Potential Residents Residents with orders for insulin administration have the potential to be affected. An audit of physician orders residents with orders for insulin administration were reviewed on 11/12 and no other insulin administration or were in need of clarification.	e for 2/18 ders		
	hypoglycemia (5) and The most recent MD assessment, a quart assessment reference	phrenia (4), depression, and repeated falls. PS (minimum data set) terly assessment, with an one date of 9/13/18, coded the cored 13 out of 15 on the		Licensed nurses were re-educated on 10/29/18 on appropriate physicians or for insulin administration. 3.Systemic Changes A weekly audit of physician orders will	ders		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/	25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
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F 658	the resident was cog decisions. The MDS having the diagnosis receiving insulin 7 da Resident #74's care prediction of the most of the mos	for mental status) indicating nitively intact to make daily also coded the resident as of diabetes mellitus and as ys a week." plan dated 9/24/18 titled elated to Insulin Dependent emia" documented, on per physician orders. hypoglycemia: weakness, ision changes, changes in to the (POS) dated 10/18/18 og Flexpen 100 unit/ ML ocutaneous twice daily with diabetes may hold for low at an October 2018 ation record (MAR) also og Flexpen 100 unit/ ML ocutaneous twice daily with diabetes may hold for low diabetes diabet	F6	completed for 25 orders for insulin that the orders ar need of clarificati non-compliance of corrected and state counselled. 4. Monitoring The results of all	will be immediately aff responsible will be aff responsible will be audits will be forward amittee for review and s.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	.ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,
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F 658	Resident #74's POdocumenting "Novo ML (milliliters) 4 unit with lunch and dinnow blood sugar" w. #7 was asked if Re was clear, LPN #7 'low blood sugar' is she would hold the LPN #7 replied, "I o Novolog order show On 10/25/18 at app Resident #74's POdocumenting "Novo (milliliters) 4 units solunch and dinner for blood sugar" was remander. When as order was clear, LF don't know what 'loof as low another in what should be dor the medication, LPI doctor and clarify the On 10/25/18 at app (administrative staff Administrator and A Nursing were made. The facility policy ti Obtaining and Trandocumented, "Med	roximately 10:49 a.m., S (dated 10/18/18) bLog Flexpen 100 unit/ is subcutaneous twice daily er for diabetes may hold for as reviewed with LPN #7. LPN isident #74's Novolog order replied "No. The part about the unclear." When asked when insulin based on the order, is lon't know." LPN #7 stated the idld be clarified with the doctor. Foximately 10:49 a.m., S (dated 10/18/18) bLog Flexpen 100 unit/ ML in the insulin based on the order, is lon't know." LPN #7 stated the idld be clarified with the doctor. Foximately 10:49 a.m., S (dated 10/18/18) bLog Flexpen 100 unit/ ML in the insulin based with LPN #6, the Unit is ked if Resident #74's Novolog in #6 replied "No, because we w' means. What I might think in the unit is order prior to giving in the insulin bloom in the insulin bl	F 65	8	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	10.20.20	
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F 658	etc." The facility por Risk Medications: Mincreased potential of error and the consect be devastating. Medications are: insulin, which is a setting are: insulin, to as the order on the method is a setting are insuling a setting are insuling a setting are: insulin is a hormore into your cells to give insulin, too much glow insuli	ers pertaining to ood pressures; blood sugars, blicy also documented, "High redications that have an of causing harm if used in quences of those errors can lications identified in this warfarin and heparin." Ided: "Insulin Administration" of insulin to tes. The type of insulin, s, strength, and method of be verified before sure that it corresponds with dication sheet and the On was provided prior to exit. In the type of insulin, so the time that helps glucose get the them energy. Without the cose stays in your blood. The sobtained from the website: gov/diabetesmedicines.html. In the type of insulin, so the time that helps glucose get the them energy. Without the cose stays in your blood. The type of insuling the time that helps glucose get the them energy without the cose stays in your blood. The time that helps glucose get the them energy without the cose stays in your blood. The time that helps glucose get the them energy without the cose stays in your blood. The time that helps glucose get them energy without the cose stays in your blood. The time that helps glucose get them energy without the cose stays in your blood. The time that helps glucose get them energy without the cose stays in your blood. The time that helps glucose get them energy without the cose stays in your blood. The time that helps glucose get them energy without the cose stays in your blood. The time that helps glucose get them energy without the cose stays in your blood. The time that helps glucose get them energy without the cose stays in your blood. The time that helps glucose get them energy without the cose stays in your blood. The time that helps glucose get them energy without the time that helps glucose get them energy without the time that helps glucose get the time that help	F 65	58		

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F 658	3. A chronic disease is regulate the amount of information was obtain https://www.nlm.nih.gu 001214.htm. 4. A mental disorder the difference between with information was obtain https://medlineplus.go 5. Hypoglycemia meas blood sugar. Your book enough energy. If you blood sugar can be districted: hunger, shaked difficulty speaking, fee information was obtain https://medlineplus.go 6. Insulin aspart (Nowmanmade version of works by replacing the produced by the body from the blood into ot used for energy. It als producing more sugar obtained from the well-	ov/huntingtonsdisease.html n which the body cannot of sugar in the blood. This ned from the website: ov/medlineplus/ency/article/ hat makes it hard to tell the hat is real and not real. This ned from the website: ov/ency/article/000928.htm. In slow blood glucose, or dy needs glucose to have a have hypoglycemia, your angerously low. Signs iness, dizziness, confusion, teling anxious or weak. This ned from the website: ov/hypoglycemia.html (volog) is a short-acting, thuman insulin. Insulin aspart the insulin that is normally or and by helping move sugar ther body tissues where it is so stops the liver from the r. This information was	F6	558				
F 684	information was obtain https://www.nejm.org/	cose - 75-115 mg/dL. This ned from: /doi/suppl/10.1056/NEJMcpc mcpc049016_tables.htm	F 6	684			12/1/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		10/2	25/2018		
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 684 SS=D	Continued From page 105 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure		F 68	4				
	accordance with prof practice, the compre care plan, and the re This REQUIREMEN' by: Based on observation record review, it was failed to ensure care	on, staff interview and clinical determined that facility staff was provided in accordance person-centered care plan for		Corrective Action Facility staff have been re-educat 10/29/18 on communicating with # 42 by speaking directly in her least terms.	resident			
	order and comprehe communicate verball directing their speech. The findings include: Resident # 42 was a 11/03/15 with diagnor not limited to: vision heart failure (1), dystand cerebrovascular. Resident # 42's mos set), a quarterly asset (assessment reference.	y with Resident # 42 by n to her left ear. dmitted to the facility on ses that included but were loss, both eyes, hearing loss, ohagia (2), hemiplegia (3) disease (4). t recent MDS (minimum data essment with an ARD ce date) of 08/23/18, coded		2.Other Potential Residents Residents that have a care plan t addresses communication proble the potential to be affected. An audit and observation of 25% residents with communication prohas been completed to validate thare familiar with and following the residents plan of care. Any area non-compliance has been correct the appropriate staff have been counselled. 3. Systemic Changes	of oblems nat staff			
		oring a 5 (five) on the brief status (BIMS) of a score of 0 severely impaired of		A 25% audit was completed on 1 care plans/observations for reside				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	cognition for making a 42 was coded as requor one staff member if use and bed mobility of one staff member if hygiene and bathing. Speech and Vision or "B0200 Hearing: 2 (to B1000 Vision: 4 (four vision or sees only light do not appear to follood on 10/24/18 at 9:07 a resident # 42's room nursing assistant) # 3 room. CNA # 3 was a Resident # 42 on the 3 set up the Resident over-the-bed table, sa of Resident # 42 and from the resident's rigor observed speaking to right side throughout was sitting up in bed. second staff member # 42's room during the side of the bed and second staff member # 42's room the side of th	daily decisions. Resident # uiring extensive assistance for locomotion, eating, toilet and being totally dependent for dressing, personal Section B "Hearing, coded Resident # 42 as wo) - Moderate difficulty,) - Severely impaired - no ght, colors or shapes, eyes w objects." a.m., an observation of revealed CNA (certified a entered Resident # 42's observed speaking to resident's right side. CNA # at # 42's breakfast tray on the at in a chair on the right side assisted her with breakfast ght side. CNA # 3 was o Resident # 42 from her the meal. Resident # 42 During the observation, a CNA # 6 entered Resident e meal, stood at the right poke to the resident. CNA # ating her to Resident # 42 and raising esident heard her and extimately 9:07 a.m., an ent # 42's room revealed a e head of the bed that f Resident) is completely	F	684	communication problems will be completed weekly to validate that staff familiar with and following the residents plan of care. Any areas of non-complia will be immediately corrected and the appropriate staff will be counselled. 4. Monitoring The results of all audits will be forwards to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18 4. The results of all audits will be forwarded to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	s nce	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 684	headphones on. CN closed the door to p Resident # 42. At 6 conducted with CNA providing care. Whe 42's hearing CNA # hearing but she hea her head set and tel Sometimes I have to her ear." When ask CNA # 4 stated, "He On 10/25/18 at 8:55 right side of the bed with breakfast. The speaking to Resider The POS (physician 10/01/2018 thru 10/3 documented, "Diagr The comprehensive with a target date of "Focus: Difficulty co hearing loss/deafnedirectly into left ear." it documented, "Rer slower/louder into left o1/23/2018." Interview 10/25/18 Conducted with CNA Resident # 42 had ar # 3 stated, "(Reside hear in her right ear 42 had any specific speaking with her, Comprehensive with a stated, "Conducted with CNA Resident # 42 had ar # 3 stated, "Conducted with CNA Resident # 42 had any specific speaking with her, Conducted with her her her her her her her her her he	alled she was lying in bed with NA# 4 entered the room and rovide personal care to 100 p.m., an interview was 1 at 4 when she finished en asked about Resident # 4 stated, "She's hard of 1 ars you pretty good. I take off 1 her what I'm going to do. 10 speak up or I get close to 10 ed which ear she speaks into, 10 right side." a.m., a staff member on the 1 was assisting Resident # 42 staff member was observed 1 at 42 on her right side. 's order sheet) dated 131/2018 for Resident # 42 anosis: Deaf in right ear." care plan for Resident # 42 anosis: Deaf in right ear." care plan for Resident # 42 anosis: Deaf in right ear." care plan for Resident # 42 anosis: Deaf in right ear. Need to talk 1 under "Interventions/Tasks" mind staff to speak	F	584				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		1	0/25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
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F 684	talk into the left ear." of the observation on CNA # 3 stated, "We hear and there isn't e of her bed for a chair. a plan for Resident # approach to speak to not aware of any plan When asked if she had care plan, CNA # 3 stated the care plan on the end how to take care of the communication care previewed on the kiosk asked to read the communication care previewed on the kiosk asked if she was follow plan for speaking into stated, "No not composite of the conducted with LPN (9, unit manager. Who sensory deficits Residual stated, "Her sensory hard of hearing." Who observation of the sign staff speaking to Resensory the sensory that of the sign staff speaking to Resensory the sensory that of the sign staff speaking to Resensory the stated, "I mean part when asked if there were use, LPN # 9 stated, into her left side." On 10/25/18 at approximation and ASI administrator and ASI and the sign staff speaking to Resensory the stated, into her left side."	After CNA #3 was informed 10/24/18 during breakfast, talk loud enough so she can nough room on the left side " When asked if there was 42 that outlined an her, CNA # 3 stated, "I'm as to how to speak to her." ad access to Resident # 42's rated, "We have access to electronic kiosk that tells us are resident." The blan for Resident # 42 was with CNA # 3. When nmunication care plan, CNA into the left ear." When wing Resident # 42's care her left ear, CNA # 3 letely." a.m., an interview was licensed practical nurse) # en asked what type of dent # 42 had, LPN # 9 deficits are that she is blind en informed of the in in the room and of the ident # 42's right ear, LPN # tially deaf, deaf in right ear." was a strategy for staff to "They should be speaking ximately 12:45 p.m., ASM member) # 2, the M # 2, assistant 4 assistant administrator,	F 6	84			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION (X3) DATE COMP		E SURVEY PLETED
		495227	B. WING	 	10	/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
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F 684	Continued From page	e 109	F 68	34		
	medical director were findings.	e made aware of the				
	No further information	n was provided prior to exit.				
	to pump oxygen-rich efficiently. This cause throughout the body. obtained from the we https://medlineplus.gd (2) A swallowing diso obtained from the we https://www.nlm.nih.gsorders.html. (3) Also called: Hemil Quadriplegia. Paraly function in part of you something goes wron pass between your bit can be complete or p	pov/ency/article/000158.htm. rder. This information was bsite: pov/medlineplus/swallowingdi plegia, Palsy, Paraplegia, sis is the loss of muscle are body. It happens when ag with the way messages rain and muscles. Paralysis artial. It can occur on one or dy. It can also occur in just				
	information was obtainttps://medlineplus.go	ined from the website: ov/paralysis.html.				
	brain stops. A stroke attack." If blood flow few seconds, the brai oxygen. Brain cells ca damage. This informa website:	lood flow to a part of the is sometimes called a "brain is cut off for longer than a in cannot get nutrients and an die, causing lasting ation was obtained from the				
F 695		ov/ency/article/000726.htm . stomy Care and Suctioning	F 69	95		12/1/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	ID NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			20/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695 SS=E	CFR(s): 483.25(i) § 483.25(i) Respirate tracheostomy care at The facility must ensineeds respiratory care and tracheal sucare, consistent with practice, the comprecare plan, the reside and 483.65 of this standard tracheal sucare, consistent with practice, the comprecare plan, the reside and 483.65 of this Standard tracheal sucare, consistent with practice, the comprecare plan, the reside and 483.65 of this standard tracheal sucare plan, the reside and 483.65 of this standard tracheal sucare plan, the resident review, and the surval occurrence and professional standard residents in the surval 10, 64, 265, 266, and 1. The facility staff facilit	ory care, including and tracheal suctioning. Sure that a resident who re, including tracheostomy ctioning, is provided such professional standards of hensive person-centered ants' goals and preferences, subpart. To is not met as evidenced on, staff interview, facility and clinical record review, it facility staff failed to provide services consistent with ds of practice for six of 46 ey sample, Residents #108, and 73. To is not met as evidenced on, staff interview, facility and clinical record review, it facility staff failed to provide services consistent with ds of practice for six of 46 ey sample, Residents #108, and 73. To it is not met as evidenced on, staff interview, facility and clinical record review, it facility staff failed to provide services consistent with ds of practice for six of 46 ey sample, Residents #108 is it is including the nasal cannula of the clarify Resident #64's failed to clarify Resident #64's failed to store Reside	F	695	1. Corrective Action Oxygen orders have been clarified for Residents # 108 and # 64. The physicians order for oxygen for resident #110 has been discontinued o 10/24/18. C-PAP mask for resident # 265 was covered on 10/25/18. Oxygen tubing for resident #266 was replaced on 10/25/18 replaced and sto in a sanitary manner The oxygen flow rate for Resident #73 was set to 2 lpm per physician order or 10/24/18. Nursing staff were re-educated on 10/29/18 on acceptable oxygen orders and the need to include the specific amount of liters per minute of oxygen thresident is receiving.	red	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/	25/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 .0,	20/2010
				73	300 FOREST AVE		
WESTPOR	RT REHABILITATION A	ND NURSING CENTER		R	ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From pa	ge 111	F 6	195			
	sanitary manner.				Nursing staff were re-educated on 10/29/18 on following physicians order	'S	
	6. The facility staff the physician order	failed to administer oxygen per for Resident #73.			for amount of liters per minute of oxyg the resident is receiving and adequate monitoring the residents oxygen		
	The findings include: saturation level.						
	1. Resident #108 w 9/28/18 and readmi diagnoses that inclu acute and chronic r heart failure, chroni			Nursing staff were re-educated on 10/29/18 on sanitary storage and practices in regard to respiratory equipment.			
		uscle weakness, and type two			2.Other Potential Residents		
	comprehensive MD assessment had no	S (minimum data set) of yet been completed. documented in the nursing			Residents who are receiving respirator therapy have the potential to be affected	-	
	place, time).	t and oriented x3 (person,			An audit/observation of residents receiving respiratory therapy has been completed to validate that they have a	n	
	made of Resident # wheelchair with her	4 a.m., an observation was £108. She was sitting up in her nasal cannula in place. Her as set at 4 liters per minute.			appropriate order for oxygen, including specific flow rate, adequate monitoring the residents oxygen saturation level a to validate that all respiratory equipme store in a sanitary manner.	of Ind	
	made of Resident # wheelchair with her	5 p.m., an observation was 4108. She was sitting up in her nasal cannula in place. Her as set at 4 liters per minute.			Any areas of non-compliance has been corrected and staff responsible have b counseled.		
		00 a.m., an observation was £108. She was sitting up in her			3. Systemic Changes		
		nasal cannula in place. Her as set at 4 liters per minute.			An audit/observation of residents receiving respiratory therapy will be completed weekly x 3 months to validation	ate	
	Resident #108. She wheelchair with her	0 a.m., an observation was e was sitting up in her nasal cannula in place. Her as set at 2 liters per minute.			that the resident has an appropriate or for oxygen, including the specific flow a adequate monitoring of the residents oxygen saturation level and to validate	der rate,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495227	B. WING _			10.	/25/2018
	ROVIDER OR SUPPLIER	ID NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 800 FOREST AVE ICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 695	order sheet dated 10 oxygen order: "02 (o minute) via NC (nasa - may remove prn (a discontinued on 10/2 order: "02 C (continucannula - may remove Review of her Octobadministration record signing off on the TA liters was in place ur order was changed the evidence showing the Resident #108 was revealed that staff with that oxygen 2-5 liters from October 24th ur 25th. There was no example amount of liters Resishift. Review of the weigh oxygen saturations for There was no evider amount of liters Resishift. Review of the Octobato evidence consisted A nursing note dater following: "Resident see TO (telephone)."	#108's most recent telephone 0/17/18 revealed the following xygen) 2-4 lpm (liters per al cannula) cont (continuous) s needed)." This order was 24/18 with the following active lous) 2-5 lpm via nasal we prn (as needed)." er 2018 TARs (treatment d) revealed that staff were R every shift that oxygen 2-4 ntil October 24th when the lough 2-5 liters. There was no leue exact amount of liters receiving per shift. er October 2018 TARS lever signing off on the TAR lever signing off on the TAR lever was in place every shift lintil current date of October levidence showing the exact lident #108 was receiving per level and vital sign log revealed loor the month of October. loce showing the exact lident #108 was wearing when	F	695	that all respiratory equipment is store is sanitary manner. 4. Monitoring The results of all audits will be forward to the QAPI Committee for review and recommendations. 5. Date of compliance 12/1/18	led	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVICE COMPLETED			
		495227	B. WING _		10)/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIF 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 695	On 10/25/18 at 9:35 conducted with LPN the nurse manager. determine how many on, LPN #4 stated the physician's order for sometimes the docto oxygen ranges such asked how the nurse liters of oxygen to acked that she proposed that the proposed form of the propose	in the clinical record ason Resident #108's oxygen on 10/24/18. a.m., an interview was (licensed practical nurse) #4, When asked if nurses can y liters of oxygen a resident is	F	695		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	OATE SURVEY OMPLETED
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		10,23,23,10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	was changed from 2 LPN #4 stated that of was in a pulmonary fibrosis. LPN #4 stated that of was in a pulmonary fibrosis. LPN #4 stated that she was check. When asked know to decrease he documentation evidestated that she would documented in the result of 2-4 lpm or 2-5 lpm would personally stated that she was amount of liters (2 lpm edded within the or asked if all nurses we stated that she was nurses could determ oxygen a resident nrange. When asked (amount of oxygen in LPN #5 stated that was needed would know how may resident was on at the saturation check if the resident was receiving clinical record, LPN know for her shift with the was not the saturation of the shift with the saturation check if the resident was receiving clinical record, LPN know for her shift with the was not the saturation of the shift with the was received the saturation of the shift with the saturation of the satur	esident #108's oxygen order 1-4 to 2-5 lpm on 10/24/18, on 10/24/18 Resident #108 crises from pulmonary ted that Resident #108 was so on 10/24/18. When asked is still on 5 liters, LPN #4 of the sure and would have to show nursing staff would for 5 liters if there was no encing monitoring, LPN #4 do see if monitoring was sursing notes. 4 a.m., an interview was #5. When asked how ow many liters of oxygen to lent with an order for a range on the lowest of liters of liters of liters of liters of liters of lowed within the ordered how oxygen saturations on the blood) was monitored, wital signs were obtained once led that vitals were also when asked how she long is not documented in the left stated that she would only then she checked. When would monitor the need for	F6	95		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		10/25/2018
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 695	know. On 10/25/18 at 12:4 administrator, ASM #3, the assistant ad assistant administrat (Director of Nursing director were all maconcerns. The facility policy tidid not address clarather facility policy di "Documentation: Af set-up or adjustmer should be recorded record:3. The rationale." 2. The facility staff the #110's oxygen tubir was not on the floor Resident #110 was 9/24/18 with diagnor limited to Parkinsor dementia without be hypothyroidism, high congestive heart farecent MDS (minimal a thirty day schedul (assessment refere Resident #110 was intact in the ability the 13 out of possible 1 for Mental Status) etc.	N #5 stated that she wouldn't A7 p.m., ASM #1, the senior #2, the administrator, ASM Iministrator, ASM #4, the other ator, ASM #5, the DON I) and ASM #4, the medical ade aware of the above Aled, "Oxygen Administration" rifying orders oxygen orders. In occumented the following: After completing the oxygen Int, the following information In the resident's medical I are of oxygen flow, route and A ailed to ensure Resident Ing; including the nasal cannula	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		,	0/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 7300 FOREST AVE RICHMOND, VA 23226		0.20.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	walking, locomotion and personal hygier On 10/23/18 at 4:04 made of Resident # wheelchair. She had her room that was cannula included) with tubing was dated 10 asked if she used his tated that sometime. On 10/24/18 at 9:51 made of Resident # sitting up in her who concentrator was of 10/20 was rolled up Resident #110 state oxygen the night prishe could not reach wheelchair. On 10/24/18 at 4:57 oxygen tubing dated stored in a plastic become of the concentrator of the concentrator was of 10/20 was rolled up Resident #110 state oxygen the night prishe could not reach wheelchair. On 10/24/18 at 4:57 oxygen tubing dated stored in a plastic become of Resident dated 10/2/18 docu "May wear 02 via N (liters a minute) for needed)."	e from one staff member with dressing, eating, toileting, ne. In p.m., an observation was the p.m., an observation was the p.m. an oxygen concentrator in the properties of t	F 69	5			

	OF DEFICIENCIES CORRECTION			DATE SURVEY COMPLETED		
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 695	evidence that Reside oxygen since it was of the oxygen since it was ever to have to place in a plastic bag for us been on the floor." On 10/25/18 at 10:54 conducted with LPN is be done if nursing staffoor, LPN #5 stated to changed and not reus oxygen tubing should reasons. When asked to reach her own oxygen the oxygen	a.m., an interview was (licensed practical nurse) #4, When asked what should be see a residents oxygen PN #4 stated nursing staff ne contaminated tubing in the ew one. When asked if it ce the contaminated tubing se, LPN #4 stated, "Not if it's #5. When asked what should aff see oxygen tubing on the that the tubing should be sed. LPN #5 stated that the diesed. LPN #5 stated that the diesed. LPN #5 stated that the diesed that Resident #110 concentrator from her bed or stated that Resident #110 concentrator from her bed or later than the diesed that Resident #110 concentrator from her bed or stated that Resident #110 concentrator from her bed or later than the diesed that Resident #110 concentrator from her bed or later than the diesed that Resident #110 concentrator from her bed or later than the diesed that Resident #10 concentrator from her bed or later than the diesed that Resident #110 concentrator from her bed or later than the diesed that Resident #10 concentrator from her bed or later than the diesed that Resident #110 concentrator from her bed or later than the diesed that Resident #110 concentrator from her bed or later than the diesed that Resident #110 concentrator from her bed or later than the diesed that Resident #110 concentrator from her bed or later than the diesed than the	F	695		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	TIPLE CONSTRUCTION (X3) DATE SU COMPLE*		ATE SURVEY DMPLETED
		495227	B. WING _	 		10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 695	monitoring of the re Resident #64 was a 9/7/18 with diagnos limited to nondispla repeated falls, unsp (chronic obstructive weakness, and uns behavioral disturbal recent MDS (minim a thirty day schedul (assessment refere #64 was coded as t cognitive function s on the BIMS (Brief I Exam). Resident # (Special Treatments as receiving Oxyge On 10/23/18 at 11:2 and 4:18 p.m., obse Resident #64. He w nasal cannula conn concentrator that wi On 10/24/18 at 9:00 made of Resident # oxygen via nasal ca concentrator. Review of Resident (physician order she order: "02 2-3 lpm (cannula- may remo	failed to evidence adequate sidents oxygen saturation. Idmitted to the facility on es that included but were not ced fracture of the left femur, recified osteoarthritis, COPD pulmonary disease), muscle pecified dementia without nce. Resident #64's most um data set) assessment was ed assessment with an ARD nce date of 10/4/18. Resident being moderately impaired in coring 09 out of possible 15 interview for Mental Status 64 was coded in Section O s., Procedures, and Programs) in therapy. 20 a.m., 12:21p.m., 2:30 p.m., ervations were made of ras on 2 liters of oxygen via ected to an oxygen	F 6	95		
	administration recor	rd) revealed that staff were AR every shift that oxygen 2-3				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From pag	ge 119	F	695			
		here was no evidence mount of liters Resident #64 nift.					
	oxygen saturations f There was no evider	its and vital sign log revealed for the month of October. nce showing the exact ident #64 was receiving when n was obtained.					
		per 2018 nursing notes failed ent oxygen monitoring.					
	dated 9/14/18 docur "Resident is at risk for related to lung disea medications/treatme Administer oxygen p	#64's respiratory care plan mented the following: or respiratory impairment useInterventions: Administer ents per physician's orders, per physician order, Obtain s]/diagnostic tests as ordered cian of results"					
	conducted with LPN the nurse manager. determine how many on, LPN #4 stated the physician's order for sometimes the doctor oxygen ranges such asked how the nurse liters of oxygen to ac #4 stated that she passon that nurses could When asked how nursed if a resident's pulse if a resident's pulse showing the amount	a.m., an interview was (licensed practical nurse) #4, When asked if nurses can y liters of oxygen a resident is nat there had to be a roxygen. LPN #4 stated that or would give an order for as 2-4 liters etc. When es know exactly how many dminister to a resident, LPN ersonally liked having ranges use their nursing judgement. ursing would know when to ow meter, LPN #4 stated that ox (oxygen saturation reading of oxygen in the blood) ey would bump it up until the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETION DATE	
F 695	that they would but the flow meter with needed. When as monitor to see if of LPN #4 stated that a day or as needed would monitor a reamount of liters with TARS or on the villooking at this (Taknow how many life to 2 (oxygen) was of what your saying, resident up or low liters of 02 could be note. On 10/25/18 at 10 conducted with LF nurses determine administer to a resident up or low liters of 2-4 lpm or 2-5 life would personally standard within the asked if all nurses stated that she was nurses could deteoxygen a resident range. When ask (amount of oxygen LPN #5 stated that a shift. LPN #5 stobtained as needed would know how resident was on a saturation check if	arge 120 It was stable. LPN #4 stated amp up the flow meter or lower thin the ordered ranges as ked how often they would axygen needed to be adjusted, at vitals were taken at least once and. When asked how nursing resident wearing oxygen if the as not documented on the stal sign log, LPN #4 stated, TARS and Log) you would not sters a resident was on when the checked." LPN #4 stated, "I see I wouldn't know to bump rer." LPN #4 stated that the per documented in a nursing and state the resident on the lowest the lipm) and gradually increase if ordered parameters. When as would know to do this, LPN #5 as not sure. LPN #5 stated that rmine that amount of liters of a needs within the ordered red how oxygen saturations in in the blood) was monitored, at vital signs were obtained once atted that vitals were also red. When asked how she many liters of 02 (oxygen) at the time of the oxygen of the amount of liters the iving is not documented in the	F	595			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495227	495227 B. WING		10/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	know for her shift wasked how nursing oxygen if there was documentation, LPN know. On 10/25/18 at 12:4 administrator, ASM #3, the assistant administrat (Director of Nursing director were all maconcerns. 4. The facility staff 265's C-PAP (continmask in a sanitary number of the continuation of the continuation of the continuation of the facility's "Admis 10/16/18 for Resident # 265's ME not due to be complimentation of the facility's "Admis 10/16/18 for Reside (brief interview for number of the conducted with Resident with Resid	#5 stated that she would only hen she checked. When would monitor the need for no evidence of this N #5 stated that she wouldn't P.T.P.m., ASM #1, the senior #2, the administrator, ASM ministrator, ASM #4, the other ator, ASM #5, the DON and ASM #4, the medical de aware of the above failed to store Resident # nuous positive air pressure) manner. #5 admitted to the facility on oses that included but were non's disease (1), anemia on (3). #6 (minimum data set) was leted at the time of survey. It is sion Assessment ator (5) date of the ent # 265 documented, "BIMS mental status) - Severe ent # 265 was coded as er of one staff member for	F 6	95		

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495227	B. WING		10/25/2018
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 695	Continued From pa	age 122	F 69	5	
	wheelchair. Observed of the bedside table mask lying inside to the second of the bedside table was lying inside the drawn of the TAR record) for Resider 10/31/18" failed to the posterior Review of the POSterior Resident for Resident to the posterior record of the poster	25 p.m. Resident # 265 in revation revealed the top drawer e was open and the C-PAP he drawer uncovered. 1. Resident # 265 in breakfast in her room. led the top drawer of the open and the C-PAP mask awer uncovered. 1. (treatment administration of the # 265 dated "10/16/18 thru evidence the use of a C-PAP. 2. (physician's order sheet) # 265 dated "10/16/18 thru evidence the use of a C-PAP.			
	plan was not due to 265. Review of the Resident # 265 day evidence the use of Review of the facility assessment for Refailed to evidence to 10/24/18 at 2:3 (licensed practical respiratory equipment tubing, C-PAP mass be stored, LPN # 8 a bag." When ask ensuring the respiratory than the storement of the respiratory to the storement of the storement of the respiratory than the storement of the st	survey, the comprehensive care to be completed for Resident # a baseline care plan for ted 10/17/2018 failed to of a C-PAP. ity's nursing admission esident # 265 dated 10/16/2018 the use of a C-PAP. ity p.m., an interview with LPN nurse) # 8. When asked how tent (nasal cannula, oxygen sk and nebulizer mask) should a stated, "It should be stored in ed who was responsible for ratory equipment is stored stated, "The nurse." When			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING	B. WING		10/25/2018	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	8 stated, "For infection of the observation of mask, LPN # 8 state On 10/24/18 03:06 pconducted with Resi LPN # 8. Resident # C-PAP was brought 265 stated, "This pathaven't used it yet." On 10/25/18 at appr (administrative staff administrator and AS administrator, ASM # 5 director of medical director wer findings. No further information References: (1) A type of movem	on control." When informed Resident # 265's C-PAP d, "It should be bagged." o.m., an interview was dent # 265 in the presence of 265 was asked when the into the facility. Resident # st Sunday (10/21/18) but I oximately 12:45 p.m., ASM member) # 2, the SM # 2, assistant # 4 assistant administrator, nursing and ASM # 6, e made aware of the	F	695	,		
	https://www.nlm.nih.sease.html. (2) Low iron. This int the website: https://www.nlm.nih. (3) High blood press obtained from the wehttps://www.nlm.nih.essure.html.	gov/medlineplus/parkinsonsdi formation was obtained from gov/medlineplus/anemia.html ure. This information was					

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495227	7 B. WING		,	0/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	•		
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F 695	10/16/18 with diagnost limited to: atrial in hypertension (3). Resident # 266'sMD not due to be comploud to be	admitted to the facility on oses that included but were fibrillation (1), anemia (2), and as set of the facility was eted at the time of survey. It is is a set of the facility of the facilit	F 69	95			
	Resident # 266 date	administration record) for ed "10/16/18 thru 10/31/18 a nasal cannula @ 2LPM."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	·	7300	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESCRIPTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 695	Continued From page 125		F	695			
	Review of the TAR received oxygen by minute from 10/17/1 review of the TAR received oxygen by minute from 10/17/1 review of the TAR received oxygen was disconting the "Physician's tele 10/24/18 documented to 266. Review of the Exception of the Oxygen should be bagged." On 10/24/18 at 2:32 (licensed practical in respiratory equipment tubing, C-PAP mask be stored, LPN # 8 stor	evealed Resident # 266 nasal cannula at two liter per 8 through 10/24/18. Further evealed Resident # 266's nued on 10/24/18. ephone Order" dated ed, D/C oxygen." rvey, the comprehensive care be completed for Resident # paseline care plan for d 10/17/2018 did not nition for the storage of sal cannula or oxygen tubing. p.m., an interview with LPN urse) # 8. When asked how nt (nasal cannula, oxygen and nebulizer mask) should estated, "It should be stored in d who was responsible for tory equipment is stored ated, "The nurse." When uld be stored in a bag, LPN # on control." When informed f Resident # 266's nasal tubing, LPN # 8 stated, "It					
	No further information	on was provided prior to exit.					

		1 ' '			(X3) DATE SURVEY COMPLETED	
	495227	B. WING _	B. WING		10/25/2018	
	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DDE		
SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
Continued From pa	ge 126	F	695			
heartbeat. This informs the website: https://www.nlm.nih on.html. (2) Low iron. This in the website: https://www.nlm.nih (3) High blood press obtained from the whttps://www.nlm.nih essure.html. 6. The facility staff of the physician order Resident #73 was a 12/12/97, with a recommendation with diagnoses that to: cerebral palsy [locontrol due to permidamage occurring to (1)], urinary retention disorder characterized ifficulty in breathin mucus production, obronchi. (2)], and recommendation (3)]. The most recent MI	gov/medlineplus/atrialfibrillati formation was obtained from gov/medlineplus/anemia.html gure. This information was rebsite: gov/medlineplus/highbloodpr ailed to administer oxygen per for Resident #73. Idmitted to the facility on rent readmission on 8/10/18 included but were not limited poss or deficiency of muscle anent, nonprogressive brain refore or at the time of birth. In, asthma [respiratory red by recurrent episodes of g, wheezing, cough, and thick caused by inflammation of the repiratory failure with hypoxia at of available oxygen in the					
	ROVIDER OR SUPPLIER RT REHABILITATION A SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER REGULATORY OF SUMMARY S (EACH DEFICIEN REGULATORY OF SUMMARY S (I) A problem with the website: https://www.nlm.nih on.html. (2) Low iron. This in the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website: https://www.nlm.nih . (3) High blood press obtained from the website https://www.nlm.nih . (3) High blood pr	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 126 References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillati on.html. (2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html. 6. The facility staff failed to administer oxygen per the physician order for Resident #73. Resident #73 was admitted to the facility on 12/12/97, with a recent readmission on 8/10/18 with diagnoses that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], urinary retention, asthma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the	ROVIDER OR SUPPLIER RET REHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 126 References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillati on.html. (2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 6. The facility staff failed to administer oxygen per the physician order for Resident #73. Resident #73 was admitted to the facility on 12/12/97, with a recent readmission on 8/10/18 with diagnoses that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], urinary retention, asthma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the blood (3)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the	ROUDER OR SUPPLIER ASTREADARESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 126 References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillati on.html. (2) Low iron, This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/inighbloodpressure.html 6. The facility staff failed to administer oxygen per the physician order for Resident #73. Resident #73 was admitted to the facility on 12/12/97, with a recent readmission on 8/10/18 with diagnoses that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], urinary retention, astma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the blood (3)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment, a quarterly assessment, with an assessment reference date of 9/13/18, coded the	CONTIDER OR SUPPLIER TO PRESENTE AND PRINCE A SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES EACH DEFICIENCY MIST EPRECEDED BY FILL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 126 References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillati on.html. (2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . Resident #73 was admitted to the facility on 12/12/197, with a recent readmission on 81/0/18 with diagnoses that included but were not limited to. cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1), urinary retention, asthma [respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. (2)], and respiratory failure with hypoxia [inadequate amount of available oxygen in the blood (3)].	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, 7300 FOREST AVE RICHMOND, VA 23226	ZIP CODE		
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F 695	was coded as being or more staff member daily living. In Section Procedures and P	consciousness. The resident totally dependent upon one ers for all of his activities of on O - Special Treatments, grams, the resident was gen while a resident in the on the October POS nmary), signed by the 18, documented, "O2 PM (liters per minute) - may ded)." adde of Resident # 73 on mately 1:00 p.m. The resident gen on via a nasal cannula, [a gs that insert into the nose to connected to an oxygen expen concentrator was set the ball resting on the line for 2 of the top of the ball was sitting ers per minute. The resident ond time on 10/23/18 at 2:52 of set at the same rate. adde on 10/24/18 at 8:28 a.m. use via the nasal cannula. It is set in the top of the ball was sitting ers per minute. The top of the ball was sitting ers per minute. adde of Resident # 73 with LPN urse) #6 on 10/24/18 at 2:40	F	695			
	liters per minute. WI flow meter of the ox	If the rate was not set at 2 then asked how to read the gen concentrator, LPN #6 the prescribed rate should be					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	CODE		
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F 695	Resident #73's oxyge when we entered the Ma'am. It was between The October 2018 The record) documented in the oxygen was sign prescribed from 10/1/2. The comprehensive of revised on 9/24/18, do for respiratory impairs asthma." The "Intervein part, "Administer of the manufacturer's in "Flowrate: 1. Turn the prescribed by your properly read the flow flowrate line on the flowrate line on the flow flowrate line on the flowrate li	the ball. When asked if an was set at the correct rate room, LPN #6 stated, "No, en the lines." AR (treatment administration the above order for oxygen. ed off as administered as /18 through 10/25/18. Care plan dated, 5/27/15 and ocumented, "Focus: AT risk ment related to aspiration, entions/Tasks" documented xygen per physician order." Inanual documented, e flowrate knob to the setting hysician or therapist. To wheter, locate the prescribed owmeter. Next, turn the flow es to the line. Now, center (liters per minute) line G: DO NOT change the lowmeter unless a change by your physician or Staff member) #2 (the #3 (the assistant)	F	695			
	No further information	n was provided prior to exit.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
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F 697 SS=D	(1) Barron's Dictional Non-Medical Reader Chapman, page 114 (2) Barron's Dictional Non-Medical Reader Chapman, page 51. (3) Barron's Dictional Non-Medical Reader Chapman, page 286 Pain Management CFR(s): 483.25(k) §483.25(k) Pain Marthe facility must ensprovided to residents consistent with profest the comprehensive pand the residents' gother than the facility must ensprovided to residents consistent with profest the comprehensive pand the residents' gother than the facility must ensprove the comprehensive pand the residents' gother than the resident of the comprehensive pand the resident in clinical record review documentation, it was staff failed to maintal management prograthe survey sample, for the facility staff failed non-pharmacological administration of as 10/19/18. The findings include Resident #316 was a 10/11/18. Resident #316 was a 10/11/18. Resident but were not limited	ary of Medical Terms for the r, 5th edition, Rothenberg and ary of Medical Terms for the r, 5th edition, Rothenberg and ary of Medical Terms for the r, 5th edition, Rothenberg and ary of Medical Terms for the r, 5th edition, Rothenberg and standards of practice, be reson-centered care plan, bals and preferences. T is not met as evidenced and review, staff interview, and review of facility as determined that the facility in a complete pain reformed for one of 46 residents in Resident #316. Indicate the dition, Rothenberg and the review of facility and preferences. T is not met as evidenced and review of facility and review of facility are determined that the facility in a complete pain reformed for the resident #316. The resident #316 are resident #316 are resident medication to on the resident medication the resident medication to on the resident medication the resident medication to on the resident medication the resi	F 695		n d C) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	•	23/2010	
WESTBO	OT DELLA DIL ITATIONI AA	ID NUIDOING GENTER		7300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	ID NURSING CENTER		RICHMOND, VA 23226			
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F 697	Continued From pag	e 130	F 69	7			
	data set), an admiss (assessment referen the resident as being coded Resident #310 pain over the last five received non-medical Review of Resident	st recent MDS (minimum ion assessment with an ARD oce date) of 10/18/18, coded g cognitively intact. Section J 6 as reporting occasional e days and as not having ation interventions for pain. #316's clinical record 's order dated 10/11/18.		as needed orders for pain med completed on 11/12/18 to valid and documentation of non-pharmacological intervent relief of pain. Any areas of non-compliance was immediate corrected and staff responsible counseled. 3.Systemic Changes	date the use tions for tely		
	revealed a physician's order dated 10/11/18, signed by the physician on 10/14/18 for oxycodone (1) 5 mg (milligrams)- one tablet three hours as needed for moderate pain.			An 25% audit will be complete 3 months of residents with as orders for pain medication to v	needed		
	(medication administ resident was administ 10/19/18.	316's October 2018 MAR tration record) revealed the stered oxycodone on		use and documentation of non-pharmacological interventable relief of pain. Any areas of non-compliance was immediate corrected and staff responsible counseled.	tions for		
	nurses' notes) failed non-pharmacologica	I interventions were offered or to the administration of as		4. Monitoring The results of all audits will be to the QAPI Committee for revrecommendations.			
	10/16/18 documenter surgery, left total known osteoarthritis, DJD (of The care plan failed regarding non-pharm On 10/23/18 at 4:16 conducted with Resignation was asked if nurses interventions prior to pain medication to he	n care plan initiated on id, "Pain related to recent se replacement, degenerative joint disease)." to document information nacological interventions. p.m., an interview was dent #316. Resident #316 offer non-medication administering as needed er. Resident #316 stated, se does when she comes in.		5.Date of compliance 12/1/18			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		<u></u>	
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F 697	Continued From pag	je 131	F 6	97			
		y time. I think they ask every cometimes they offer an ice					
	conducted with LPN LPN #1 was asked wadministering as new residents. LPN #1 should probably try administer pain med elevate the area." Vnon-pharmacological documented, LPN #Because we want to in always giving med something else beforwhy offered non-phashould be document that they did try to diadministration of pair what is meant if offe interventions are not "If it's not document not done. I can't alw Sometimes we do of pain medication but for that." On 10/24/18 at 4:08 conducted with LPN administered oxycool 10/19/18). LPN #2 volume residents.	p.m., an interview was (licensed practical nurse) #1. what should be done prior to eded pain medication to tated, "Pain assessment and something before we ications. Ice the area, When asked if offered Il interventions should be 1 stated, "If they do it. try to- we don't want to result dication. We want to try re doing that." When asked armacological interventions ted, LPN #1 stated, "To show to something different before in medication. When asked ared non-pharmacological to documented, LPN #1 stated, ed, technically it means it's vays say it's the cause. Iffer other things prior to giving we don't give ourselves credit p.m., an interview was #2 (the nurse who done to Resident #316 on was asked what should be stering as needed pain					
	what pain they are in they are alert enoug asked if she attempt	nts. LPN #2 stated, "Ask n and where it is. Make sure h to be able to take it." When s non-pharmacological administering as needed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STAT 7300 FOREST AVE RICHMOND, VA 23226	E, ZIP CODE	
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F 697	Continued From page pain medication, LPN		F6	697		
	like that. Maybe a pil offered non-pharmac administering as need	low." When asked if she ological interventions prior to ded pain medication to #3 stated she did not recall.				
	staff member) #2 (the assistant administrate assistant administrate	or), ASM#5 (them director of (the medical director) were				
	documented, "3. Staf a comforting environr physical and compler example, local heat of	mentary interventions; for				
	(1) Oxycodone is use information was obtain	n was presented prior to exit. ed to treat pain. This ined from the website: bv/druginfo/meds/a682132.h				
F 761 SS=D	tml Label/Store Drugs an CFR(s): 483.45(g)(h)		F 7	761		12/1/18
	Drugs and biologicals	y and cautionary				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
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	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	•	
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F 761	§483.45(h)(1) In a	ge of Drugs and Biologicals	F7	761		
	Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.					
	locked, permanen storage of controll the Comprehensiv Control Act of 197 abuse, except who package drug dist quantity stored is be readily detecte	e facility must provide separately thy affixed compartments for ed drugs listed in Schedule II of the Drug Abuse Prevention and 66 and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose cand. ENT is not met as evidenced				
	Based on observed document review, facility staff failed to professional stamedications carts	ation, staff interview and facility it was determined that the to store medications according andards for one of eight, a wing four medication cart.		Corrective Action The pills that were stored in medication cups were disca 2.Other Potential Residents	arded.	
		containing various pills was lrawer of a medication cart on de:		Residents that receive med the identified medication ca have the potential to be affe	art on wing four	
	On 10/25/18 at 11 medication cart or medication cup lal pills was observed medication cart.	:48 a.m., observation of a n wing four was conducted. A beled "407b," containing various d in the top drawer of the		The nurses responsible have counseled. Licensed nurses have been on medication pass proced. 3.Systemic Changes	n re-educated	
	On 10/25/18 at 11	:52 a.m., an interview was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			10/	25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		7300 F	T ADDRESS, CITY, STATE, ZIP CODE OREST AVE MOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	(the nurse who was remedication cart). LP should be administer prepared. LPN #6 who containing various pill medication cart. LPN stated the pills should LPN #6 stated one remedication earlier in LPN #6 was shown the various pills located in cart. LPN #6 stated of pills because anoth the cart." LPN #6 stated of pills because anoth the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the cart." LPN #6 stated with the cart. "LPN #6 stated with the	(licensed practical nurse) #6 responsible for that N #6 confirmed medications red as soon as they are as asked if a medication cup red stated, "No." LPN #6 red be discarded if not needed. resident had refused his red medication cup containing red the top of the medication reshe was unaware of the cup red the other nurse should red the other nurse red the other n	F7	A mm mm let ar im re 4.	weekly observation of 50% of edication carts will be conducted x 3 onths to validate that there are no pill ft in a cup in the medication carts. An eas of non-compliance will be imediately corrected and staff sponsible will be counseled. Monitoring The results of all audits will be forwarded the QAPI Committee for review and commendations. Date of compliance 2/1/18	у	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	73	TREET ADDRESS, CITY, STATE, ZIP CODE 800 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804 SS=B	CFR(s): 483.60(d)(1) §483.60(d) Food and Each resident receiv §483.60(d)(1) Food conserve nutritive va §483.60(d)(2) Food attractive, and at a s temperature. This REQUIREMEN by: Based on observative staff interview, it was failed to serve food a one of four wings, w The facility staff faile temperature on 10/2 The findings include On 10/24/18 at appr observation was ma kitchen. The holding all of the food from to staff member) #5 us	d drink les and the facility provides- prepared by methods that alue, flavor, and appearance; and drink that is palatable, afe and appetizing T is not met as evidenced on, resident interview and a determined the facility staff at a palatable temperature on ing one. d to serve food at a palatable 4/18. c coximately 5:00 p.m., an de of the tray line in the temperatures were taken of the tray line by OSM (other ting a calibrated facility temperature of the food in tows: d degrees 160 degrees 160 degrees 166 degrees 166 degrees	F	804	1.Corrective Action Dietary staff were re-educated on 10/29/18 on appropriate temperatures food service. Nursing staff were re-educated on 10/29/18 on prompt tradelivery The facility has ordered a new plate heating system and we expect delivery within 30 days. 2.Other Potential Residents Residents that receive meals in their roon unit 1 have the potential to be affect 3. Systemic Changes An audit/observation will be completed monthly x 3 months to include taking an recording temperatures of a test tray or unit 1. Any areas of non-compliance wibe immediately corrected and staff responsible will be counseled.	y oom red. nd n	12/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP (7300 FOREST AVE RICHMOND, VA 23226	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 804	and arrived at wing or resident was served temperature was core (other staff member) using a calibrated far consisted of puree of mashed potatoes, parand lemon mousse, temperatures in Fahr Puree Chicken - 121 degrees) Puree Vegetables - degrees) Mashed Potatoes - degrees) Pasta Primavera - 1 degrees) Chicken Salad - 32 degrees) Chicken Salad - 32 degrees) Chicken Salad - 32 degrees) Three surveyors and Manager then tested palatability. When as temperature, OSM # it fails." Resident #128 was a 9/21/18. Resident # were not limited to dand urinary retention recent MDS (minimum Medicare assessme reference date) of 10 as being cognitively.	a test tray, left the kitchen one at 6:05 p.m. The last at 6:15 p.m. Testing of inducted at 6:15 p.m. by OSM of #1, the Dietary Manager cility thermometer. Test tray hicken, puree vegetables, asta primavera, chicken salad The recorded serving renheit is as follows: I degrees (decrease of 49 o	F8	4. Monitoring The results of all audits wito the QAPI Committee for recommendations. 5.Date of compliance 12/1/18		ed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		10/	/25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	, ,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 804	eats dinner in his roof food is lukewarm. Resident #119 was a 9/7/18. Resident #11 were not limited to preshortness of breath. MDS (minimum data assessment with an adate) of 10/3/18, code cognitively intact. On 10/23/18 at approximaterview was conducted buring the interview, eats dinner in her roof food is hard and cold. On 10/24/18 at approximaterview and cold. On 10/25/18 at approximaterview and cold. On 10/25/18 at approximaterview and cold. On 10/25/18 at approximaterview and cold.	Resident #128 stated he m (on wing one) and the dmitted to the facility on 19's diagnoses included but neumonia, heart failure and Resident #119's most recent set), a 30 day Medicare ARD (assessment reference ed the resident as being eximately 3:59 p.m., an otted with Resident #119. Resident #119 stated she om (on wing one) and the continuous management of the facility did not have a lature and/or palatability of eximately 12:45 p.m., ASM member) #2, Assistant that the facility 12:45 p.m., ASM member) #2, Assistant that the Director of	F 80			
F 812 SS=F		n was obtained prior to exit. tore/Prepare/Serve-Sanitary 2) ty requirements.	F 81	2		12/1/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/:	25/2018
	PROVIDER OR SUPPLIER	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			10/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	approved or considestate or local author (i) This may include from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and for (iii) This provision do from consuming foods [iii) This provision do from consuming foods [iiii] This provision do from consuming foods [iiiii] This provision do from consuming foods [iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ered satisfactory by federal, rities. If food items obtained directly is, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices. Des not preclude residents ods not procured by the facility. Determined the facility is not met as evidenced between the professional service safety. Determined that the postore, prepare and distribute the pattern and the professional service safety. Determined that the postore, prepare and distribute the pattern and the professional service safety. Determined that the postore, prepare and distribute the pattern and the postore, prepare and distribute the pattern and the professional service safety. Determined that the postore, prepare and distribute the pattern and the profession and	F	312	1.Corrective Action Food Service staff have been re-educa on kitchen sanitation requirements including, but not limited to drying of dishes, hair covering, including beards, fully immersing dishes in 3 compartmer sink, keeping kitchen floor clean, ensur utensils on tray line are clean and using clean thermometers to check food temperatures. 2. Other Potential Residents All residents have the potential to be affected. Food Service staff have been re-educa on kitchen sanitation requirements including, but not limited to drying of dishes, hair covering, including beards, fully immersing dishes in 3 compartments	nt ing g	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/	25/2018
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	The findings included 1. The facility staff fa floor in a sanitary may Observation was may at approximately 11:0 surveyors and one feentering the kitchen, ASM (administrative Assistant Administrative Assistant Administrative Hole Chef for the initial approximately 11:0 made of the floors the The kitchen floor surpreparation area appublack debris, food an asked what the black OSM #1 stated, "The comes off the shoes. Review of the kitchen 2018, documented the dish area were single moped after each see 10/1/18. An interview was cor approximately 1:35 p #5. When asked why in the kitchen be cleakeep the kitchen san	ning food temperatures on line. d: iled to maintain the kitchen anner. de of the kitchen on 10/23/18 02 a.m., with two state ederal surveyor. Upon the surveyors were met by staff member) #2, the tor, OSM (other staff tary Manager and OSM #5, I tour. in the kitchen on 10/23/18, 05 a.m., an observation was roughout the food kitchen. face throughout the food eared dirty with copious d grease. OSM #1 was a debris was on the floor, e black debris on the floor	F	312	utensils on tray line are clean and using clean thermometers to check food temperatures. 3. Systemic Changes An audit/observation will be completed weekly x 3 months to validate that saniconditions are being met in the kitchen. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring The results of all audits will be forwarde to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	tary	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		,	10/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 812	When asked how off are cleaned, OSM # person who does it so Review of facility pol documented "All kits dining area shall be and rubbish and proflies and other insection of the same of three-compartments of the same	revents slips, trips and falls." ten the floors in the kitchen 5 stated, "Daily and the signs it off in a log." licy titled, "Sanitization" thens, kitchen area and kept clean, free from litter tected from rodents, roaches, ts." oximately 12:45 p.m., ASM member) #2, Assistant SM #5, the Director of aware of the findings. on was obtained prior to exit. alied to ensure sanitation of compartment sink. or in the kitchen on 10/23/18, 10 a.m., an observation was artment sink in the kitchen. The sink was observed filled to large mixing bowls. The ded not completely submerged	F 81:				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING			10	/25/2018	
	ROVIDER OR SUPPLIER	ID NURSING CENTER	•	7300	EET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 812	#5. When asked wer compartment sink su to being cleaned, OS asked why it is imporsubmerged in sanitizareplied, "If the dishes sanitization solution of Review of the facility dated 5/2/2018 docuobjects in sanitizer si as specified by the Oproduct label and/or On 10/25/18 at appro(administrative staff in Administrator and AS Nursing were made as No further information. 3. The facility staff fastaff member) #9's (tin the food preparation. During the initial tour at approximately 11: made OSM #9, Cook a beard cover that coof his beard. On 10/24/18 at approximately 11: made OSM #9, Cook a beard cover that coof his beard. On 10/24/18 at approximately 45. When asked how covered, OSM #5 reprompletely covered."	e all the dishes in the three bmerged in sanitization prior SM #5 replied "No." When tant that the dishes be ation solution, OSM #1 are not submerged the can't clean them." policy titled, "Sanitization" mented, "c. Then submerge ink (Sink 3) for one minute or local guidelines." poximately 12:45 p.m., ASM member) #2, Assistant SM #5, the Director of local guidelines." poximately 12:45 p.m., as obtained prior to exit. illed to ensure OSM (other the cook) beard was covered on area. In the kitchen on 10/23/18, 13 a.m., an observation was as c. OSM #9 was observed with overed approximately 2/3rd's oximately 1:42 p.m., an other cooks of the cook o	F	312				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _		1	0/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 812	documented, "Hair restraints must be contacting exposed utensils and linens." On 10/25/18 at app (administrative staff Administrator and A Nursing were made No further informated. The facility staff serving utensils were buring the initial to at approximately 1 made prior to the swas made of the two green handled as of the green handled observed to have proposed to have propos	dates October 2017 nest or caps and/or beard worn to keep hair from d food, clean equipment, " broximately 12:45 p.m., ASM ff member) #2, Assistant ASM #5, the Director of e aware of the findings. ion was obtained prior to exit. failed to ensure tray line ere clean. ur in the kitchen on 10/23/18, 1:50 a.m., an observation was tart of tray line. Observation vo large ladles, a spatula; a coop and a slotted spoon. Both spoon and slotted spoon were cooled water in them. The ved to have old food debris. proximately 11:51 a.m., ade with OSM #5 of the tray s. When asked what OSM #5 replied, "Ladles with water in with some food debris." proximately 11:52 a.m., an flucted with OSM #5. When seed to serve food should have em, OSM #5 replied "No,	F8	12			
	On 10/23/18 at apprinterview was conducted asked if utensils us pooled water in the because bacteria of how are utensils sureplied "clean, dry and the state of t	oroximately 11:52 a.m., an lucted with OSM #5. When sed to serve food should have					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			10/25/2018	
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 812	dated 5/2/18 docum counters, shelves, a clean, maintained in equipment, food corshall be washed to soils by using manunecessary and sanitichemical sanitization. On 10/25/18 at app (administrative staff Administrator and A Nursing were made. No further information of the dish rate of dishes on the dishes on the dishes on the dishes on the bottom. On 10/23/18 at approximately 11 made of dishes on the bottom. On 10/23/18 at approximately 11 made of dishes on the bottom. On 10/23/18 at approximately 12 made of dishes on the bottom. On 10/23/18 at approximately 13 made of dishes on the bottom. On 10/23/18 at approximately 14 dishes on 15 may be servation was marack. When asked with the drying rack. OSM #water can pool in it.	nented, "2. All utensils, and equipment shall be kept a good repair. 3. All antact surfaces and utensils remove or completely loosen all or mechanical means tized using hot water and/or	F	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		,	10/25/2018	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 812	down." On 10/25/18 at appr (administrative staff Administrator and At Nursing were made No further information of the facility staff factor of the fa	oximately 12:45 p.m., ASM member) #2, Assistant SM #5, the Director of aware of the findings. on was obtained prior to exit. siled to clean a thermometer ning temperatures on the command of OSM #6 obtaining tray the dining room. OSM #6 ors that he did not have a coceeded to ask OSM #7 if eter. OSM #7 proceeded to out of her jacket pocket and er to OSM #6. OSM #6 then exprobe cover off the gan to take the tray line dining room. OSM #6 did not ter probe prior to taking the oximately 1:45 p.m., an octed with OSM #1 and OSM termometers should be cking temperatures on the #1 replied, "Yes, before use	F 81	12			
	Foodborne Illness- F 2014 documented, "	ood Handling" dated July					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		10/25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 812	Continued From page	minimized."	F 81	2	
	(administrative staff Administrator and A	roximately 12:45 p.m., ASM member) #2, Assistant SM #5, the Director of aware of the findings.			
F 842 SS=D		on was obtained prior to exit. Identifiable Information), 483.70(i)(1)-(5)	F 84	2	12/1/18
	(i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use of	release information that is			
	professional standa	ordance with accepted rds and practices, the facility cal records on each resident mented; ble; and			
	all information conta regardless of the for records, except who (i) To the individual,	or their resident re permitted by applicable law;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· /	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 842	operations, as per with 45 CFR 164.9 (iv) For public hean neglect, or domes activities, judicial alaw enforcement purposes, research medical examiners a serious threat to by and in compliant §483.70(i)(3) The record information unauthorized use. §483.70(i)(4) Med for- (i) The period of till (ii) Five years from there is no require (iii) For a minor, 3 legal age under States age under States and resident revied (iv) The comprehending the com	payment, or health care mitted by and in compliance 506; Ith activities, reporting of abuse, tic violence, health oversight and administrative proceedings, purposes, organ donation in purposes, or to coroners, so, funeral directors, and to avert health or safety as permitted ince with 45 CFR 164.512. Ifacility must safeguard medical ragainst loss, destruction, or it in the date of discharge when ement in State law; or years after a resident reaches tate law. In medical record must containment in to identify the resident; resident's assessments; ensive plan of care and services any preadmission screening we evaluations and inducted by the State; irse's, and other licensed	F8	1. Corrective Action			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		10)/25/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00.0	
WESTDO	DT DELIABII ITATION A	ND NURSING CENTER		7300 FOREST AVE			
WESTPOR	RI REHABILITATION A	ND NORSING CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From pag	ge 147	F8	42			
F 842	clinical record revier facility staff failed to accurate clinical record the survey sample, The facility staff failed non-pharmacological offered to Resident as needed pain med October 2018. The findings included Resident #316 was 10/11/18. Resident but were not limited tract infection and letter Resident #316's modulated tract infection and letter traction and letter the resident as bein coded Resident #31 pain over the last five received non-medical Review of Resident revealed a physicial signed by the physical signed by the physicial signed by the physicial signed by the	w, it was determined that the maintain a complete and ord for one of 46 residents in Resident #316. ed to document al interventions that were #316, prior to administering dication on multiple dates in e: admitted to the facility on #316's diagnoses included to muscle weakness, urinary eff knee osteoarthritis. est recent MDS (minimum sion assessment with an ARD nee date) of 10/18/18, coded g cognitively intact. Section J 6 as reporting occasional re days and as not having ation interventions for pain. #316's clinical record n's order dated 10/11/18 and	F 8	Licensed Nurses were re-ed 11/5/18 on the requirement to specific non-pharmacological interventions for relief of paradministration of as needed medication. It was reviewed nurses the importance of do specific intervention and the of the intervention. 2. Other Potential Residents Residents that have pain isses a physicians order for as new medication have the potential affected. An audit of 25% of as needed orders for pain macompleted on 11/12/18 to various documentation of non-pharminterventions for relief of pain of non-compliance was immacorrected and staff responsiticounseled. 3. Systemic Changes An 25% audit will be completed on 11/12/18 with a orders for pain medication to appropriate documentation of non-pharmacological interverelief of pain. Any areas of non-compliance was immed corrected and staff responsiticounseled.	to document fal in, prior to pain with the cumenting the effectiveness sues and have eded pain fal to be residents with fiedication was falidate finacological finacologi		
	10/21/18 10/22/18			4. Monitoring			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/	25/2018	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842	(including the back of nurses' notes) failed non-pharmacological to Resident #316 prioneeded oxycodone or Resident #316's pain 10/16/18 documented surgery, left total kneosteoarthritis, DJD (d) The care plan failed the regarding the document on-pharmacological On 10/23/18 at 4:16 producted with Residing was asked if nurses of interventions prior to pain medication to he "Sometimes the nurs I don't think it's every other time. Maybe so pack." On 10/24/18 at 3:54 producted with LPN (the nurse who adminoxycodone to Reside LPN #3 was asked wadministering as nee residents. LPN #3 st residents' pain and as she can do such as, offer an ice pack. Withe non-pharmacolog offers to residents, LI	sident #316's clinical record if the October 2018 MAR and to reveal interventions were offered or to the administration of as in all of the above dates. care plan initiated on id, "Pain related to recent e replacement, egenerative joint disease)." in document information entation of interventions. indexide the sident #316 offer non-medication administering as needed er. Resident #316 stated, e does when she comes in. time. I think they ask every ometimes they offer an ice indexide the sident was communicated to recent e replacement, e generative joint disease)." interventions. interventions. interventions interventions interventions interview was communicated to recent e replacement, e generative joint disease). interventions interventions interventions interventions interview was communicated to recent e replacement, e generative joint disease). interventions interventions interventions interview was communicated to recent e replacement, e generative joint disease)." interventions interventi	F8	342	The results of all audits will be forward to the QAPI Committee for review and recommendations. 5.Date of compliance 12/1/18	ed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		1	0/25/2018
	ROVIDER OR SUPPLIER	ID NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODI 7300 FOREST AVE RICHMOND, VA 23226	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	document the non-ple that she offers, LPN to. It's more for my a I can do to help her please give Resident # On 10/24/18 at 4:00 conducted with LPN should be done prior pain medication to re "Pain assessment ar something before we medications. Ice the When asked if offere interventions should stated, "If they do it. we don't want to resimedication. We war before doing that." In non-pharmacologica documented, LPN # did try to do somethin administration of pain On 10/24/18 at 5:46 staff member) #2 (the assistant administration and assistant administration of the action o	sked why she should harmacological interventions #3 stated, "I really don't have assessment to see what else bain." LPN #3 stated she #316 an ice pack. p.m., an interview was #1. LPN #1 was asked what to administering as needed esidents. LPN #1 stated, and should probably try administer pain area, elevate the area." If a don-pharmacological be documented, LPN #1 Because we want to try to, will in always giving to to try something else When asked why offered I interventions should be a stated, "To show that they are different before the medication." p.m., ASM (administrative else administrator), ASM#3 (the or), ASM#4 (another or), ASM#5 (them director of 60 (the medical director) were bove concern. ed, "Pain-Clinical Protocol" information regarding the	F 84	42		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495227	B. WING_			10/	25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	https://medlineplus.go tml	d to treat pain. This ned from the website: ov/druginfo/meds/a682132.h		342			
F 880 SS=D	infection prevention a designed to provide a comfortable environmed development and trared diseases and infection §483.80(a) Infection program. The facility must estate and control program a minimum, the follow §483.80(a)(1) A system of system of system of system of system of system of surveil providing services un arrangement based up conducted according accepted national state §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicate infections before they persons in the facility	ntrol blish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable ans. prevention and control blish an infection prevention (IPCP) that must include, at wing elements: am for preventing, identifying, and controlling infections seases for all residents, ors, and other individuals der a contractual apon the facility assessment to §483.70(e) and following and order, which must include, and order includes included inc	F	380			12/1/18

OL. VILLI	C . C. C. III. EDIO/ II LE C	MEDIO/ ND OLIVIOLO				<u> </u>	2. 0000 000 1
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 100 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	reported; (iii) Standard and trait to be followed to prev (iv)When and how is cresident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected sicontact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease of infected sicontact will transmit to (vi)The hand hygiene by staff involved in disease or infected sicontact will transmit to (vi)The hand hygiene by staff involved in disease or infected sicontact will transmit to (vi)The hand hygiene by staff involved in disease or infected sicontact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease or infected sicontact with residents contact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease or infected sicontact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease or infected sicontact with residents contact with residents contact will transmit to (vi)The hand hygiene by staff involved in disease or infected sicontact with residents contact with r	se or infections should be assistant spread of infections; plation should be used for a set not limited to: attend for the isolation, infectious agent or organism at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct is or their food, if direct he disease; and a procedures to be followed rect resident contact. The form of the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct is or their food, if direct he disease; and a procedures to be followed rect resident contact. The form of the isolation, if direct he disease; and is the facility in the facility. The form of the isolation is under the isolation is the facility in the facility is in the facility. The form of the isolation, infections, and is to prevent the spread of the isolation is in the facility in the facility is in the facility. The form of the isolation is infections, and is the isolation is infections in the facility is in the facility in the facility in the facility is in the facility in the facility in the facility is in the facility in the facility in the facility is in the facility in the	F	8880	1. Corrective Action		
	record review, it was failed to provide care	ument review, and clinical determined that facility staff in a manner to prevent fresidents in the survey			The physician order for oxygen for resident #110 was discontinued 10/24/	18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				10/25/2018
NAME OF P	ROVIDER OR SUPPLIER	l		ST	REET ADDRESS, CITY, STATE, ZIP CODE	'	
				73	00 FOREST AVE		
WESTPOR	RT REHABILITATION	AND NURSING CENTER		RI	CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From բ	page 152	F 8	380			
	sample, Resident drainage system (the ice machine	#110; and failed to maintain the for one of two ice machines, adjacent to the kitchen), in a o prevent infection.			The end of the drainpipe for the ice machine adjacent to the kitchen was corrected on 10/23/18 to allow a 2" clearance above the surface of the drains.	in.	
	#110's contamina	f failed to ensure Resident ted oxygen tubing was			2. Other Potential Residents		
	discarded and no			Residents who are receiving respirator therapy have the potential to be affected			
	1	f failed to maintain an ice					
		system in a sanitary manner			An audit/observation of residents		
		machines, the one on adjacent			receiving respiratory therapy was		
	to the kitchen.				completed on 11/9/18 to validate that t	ney	
	The findings inclu	de:			have an appropriate order for oxygen, including the specific flow rate, adequate monitoring of the residents oxygen	ate	
	1 The facility staf	f failed to ensure Resident			saturation level and to validate that all		
	1	ted oxygen tubing was			respiratory equipment is stored in a		
		t available for use.			sanitary manner.		
	9/24/18 with diag	as admitted to the facility on noses that included but were not on's disease, unspecified behavioral disturbance,			Any areas of non-compliance has been corrected and staff responsible have b counseled.		
	hypothyroidism, h congestive heart recent MDS (mini	igh blood pressure, and failure. Resident #110's most mum data set) assessment was			Residents that receive ice from the ice machine adjacent to the kitchen have potential to be affected. The end of the	the	
	(assessment refe	uled assessment with an ARD rence date) of 10/22/18. as coded as being cognitively			drainpipe for the ice machine adjacent the kitchen has been corrected to allow 2" clearance above the surface of the		
	13 out of possible	to make daily decisions scoring 15 on the BIMS (Brief Interview			drain.		
	coded as requirin	exam. Resident #110 was g extensive assistance from two			3. Systemic Changes		
		bed mobility and transfers; and			A weekly audit of 25% of residents		
		nce from one staff member with			receiving oxygen therapy will be completed to validate that they have a	n	
	and personal hyg	on, dressing, eating, toileting,			appropriate order for oxygen, including		
	and personal myg	ichic.			specific flow rate, adequate monitoring		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		10/	25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, Z 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
F 880	made of Resident wheelchair. She has cannula included) tubing was dated #110 if she used h stated that sometin On 10/24/18 at 9:5 made of Resident sitting up in her who concentrator was of 10/20 was rolled un Resident #110 states oxygen the night poshe could not read wheelchair. On 10/24/18 at 4:5 oxygen tubing dates stored in a plastic On 10/25/18 at 10 oxygen concentrator room. Review of Resider dated 10/2/18 documents a minute of the could not read wheelchair. Review of Resider dated 10/2/18 documents a minute of the could not read wheelchair. Review of Resider dated 10/2/18 documents a minute of the could not read wheelchair. Review of Resider dated 10/2/18 documents a minute of the could not read wheelchair.	A4 p.m., an observation was #110. She was sitting up in her ad an oxygen concentrator in off. The oxygen tubing (nasal was laying on the floor. The 10/20. When asked Resident er oxygen, Resident #110 mes she wore it at night. A1 a.m., an observation was #110. Resident #110 was neelchair. Her oxygen off. Her oxygen tubing dated p and stored in a plastic bag. ted that she didn't need her rior. Resident #110 stated that h her concentrator from her A57 p.m., Resident #110's ed 10/20 was still rolled up and bag. A106 a.m., Resident #110's or was removed from her A1110's telephone order sheet umented the following order: NC (nasal cannula) @ 2 Im r SOB (short of breath) prn (as at #110's October 2018 TAR estration record) revealed no ident #110 had needed her	F8	the residents oxygen sate to validate that all respinsatored in a sanitary man. 4. Monitoring The results of all audits to the QAPI Committee recommendations. 5.Date of compliance 12/1/18	ratory equipment is nner. will be forwarded		

	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————		(X3) DATE SURVEY COMPLETED				
		495227	B. WING			10/	25/2018
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	conducted with LPN the nurse manager. done if nursing staff the floor, LPN #4 stathrowing the contamgetting a new one. Vokay to place the cobag for use, LPN #4 the floor." On 10/25/18 at 10:5 conducted with LPN be done if nursing ston the floor, LPN #5 be changed and not the oxygen tubing streasons. When aske to reach her own ox wheelchair and roll i stated that Resident concentrator from her concentrator from her concentrator from her concentrator. On 10/25/18 at 12;4 administrator, ASM #3, the assistant administra (Director of Nursing) director were all macconcerns. A policy could not be above concerns. A policy could not be above concerns. The facility staff far machine drainage sy for one of two ice mather kitchen.	(licensed practical nurse) #4, When asked what should be were to see oxygen tubing on ated nursing staff should be ainated tubing in the trash and When asked if it was ever ntaminated tubing in a plastic stated, "Not if it's been on 4 a.m., an interview was #5. When asked what should taff were to see oxygen tubing stated that the tubing should reused. LPN #5 stated that hould be changed for sanitary and if Resident #110 was able yean tubing from her bed or t up in a plastic bag, LPN #5 #110 could not reach her are bed or wheelchair. 7 p.m., ASM #1, the senior #2, the administrator, ASM ministrator, ASM #4, the other tor, ASM #5, the DON of and ASM #4, the medical de aware of the above be provided regarding the ailed to maintain an ice yestem in a sanitary manner achines, the one adjacent to	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495227	B. WING		1	0/25/2018	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZI 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Administrator and 0 the Chef. The drair opening of two inch drain. A white PVC flange had been at stated the facility w splashing from the floor, thus having a drainpipe was not of from the ice machin of the drain and co the drainage pipe. On 10/23/18 at apprinterview was cond was asked is there between the drainpresponded "Yes, be water it will go up to the drainpipe on the d	of a.m., with ASM of member) #2, the Assistant DSM (other staff member) #5, upipe was not visible with an es above the surface of the (Polyvinyl chloride) cuffed tached to the drain. ASM #2 has having trouble with drainpipe causing water on the hazard. The end of the visible, thus the drainage pipe he was not above the surface have backflow of water into a proximately 11:11 a.m., an ucted with ASM #2. ASM #2 has should there be space in hipe and the drain, ASM #2 because if there is a backflow of	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			10/25/2018	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 880	On 10/25/18 at appro (administrative staff n Administrator and AS Nursing were made a	ximately 12:45 p.m., ASM nember) #2, Assistant M #5, the Director of	F8	380			